



**STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION
HEALTH CARE AND BENEFITS DIVISION**

**PO Box 200127
Helena Montana 59620-0127**

**1-800-287-8266
(406) 444-7462**

TO: Members of the State Employee Benefits Plan

FROM: Health Care and Benefits Division

DATE: September 17, 2010

SUBJECT: Changes for the 2011 Plan Year

Welcome to the Annual Benefit Change period for the 2011 plan year. This booklet contains instructions for making your benefit elections for the new plan year. Please review the booklet and its information closely. Please pay special attention to your medical plan choices for 2011 as there have been changes. You may wish to attend an Annual Change presentation to hear more information about how your benefits work and how you can make optimal use of them. You will find the schedule of presentations on pages 6 & 7 of this booklet.

This year we are offering 24 presentations via Webinar in order to allow employees and retirees participation through the internet. To participate in a Webinar, you will need a computer, internet connection and telephone. To participate in an Annual Change Webinar, please see the schedule listed on page 7 or you may visit the benefits website at www.benefits.mt.gov. There will be a Webinar presentation available on our website that may be viewed at any time.

NEW – ENROLLMENT PROCESS

Active Employees – The 2011 Annual Change Period will be paperless! This means that employees will elect their 2011 benefits through SABHRS Self Service and a paper Individual Benefits Statement **will not** be distributed. Agencies with users that do not have access to SABHRS Self-Service features are encouraged to set these employees up with a special account created by DOA ITSD. Procedures for setting up the account are available on Health Care and Benefits Division's website at benefits.mt.gov/annualchange.mcp.x.

Retirees/Legislators – For 2011, you will receive an *Individual/Retiree Benefits Statement form*. Retirees may elect their benefits on-line or by completing their *Individual/Retiree Benefits Statement form*. The on-line application offers additional personalized information to you while you are making your benefit elections, including medical plan comparisons and cost calculators. Legislators must elect their 2011 benefits using the *Individual/Retiree Benefits Statement form*.

THE DEADLINE TO SUBMIT CHANGES FOR THE 2011 PLAN YEAR IS OCTOBER 27, 2010.

Plan Status

Since the beginning of 2008, we have seen significant increases in our health care claims costs. Our medical claim costs continue to increase and account for the majority of our costs. We continue to see increases in the expenses we pay for inpatient and outpatient hospital services, while the negotiated discounts from hospitals continue to decrease. In other words, we are paying for higher charges and a receiving smaller discount, which means both the health plan and our members are paying more than ever for hospital services.

Our new URx program has resulted in tremendous savings of over 17% as compared to the past. This does not include savings from the approximate 10% annual increase in costs we were paying under our previous pharmacy plan. In 2009, our

plan was paying an average of \$474,662 per week in prescription drug claims. For the first six months in 2010, our plan is paying an average of \$392,620 per week for prescription drugs. This is a dramatic turn for a benefit that has seen enormous increases over the last three years.

Medical Plan Changes

Due to increasing claim and administration costs, the Health Care & Benefits Division has made the following benefit changes for the 2011 benefit year:

- Peak Health Plan will no longer be offered as a managed care option.
- Reliant Behavioral Health will no longer provide EAP services.
- A new benefit design for EAP services allows members that are covered under the plan who seek services from a participating or in-network provider to receive their first four visits free. Please see page 24 for additional information regarding the EAP, maternity services and weight management programs.
- Health Care Reform mandates for 26 year old dependents, elimination of pre-existing conditions for dependents under age 19 and the elimination of some of the annual and lifetime maximums.
- Out of network managed care changes: deductible moves to \$650 per member/\$1300 per family, the maximum member liability moves to \$3500 per member/\$8000 per family and co-insurance remains at 35%.

Medical Plan Rates

As of January 1, 2011, the state share contribution for benefits on behalf of active employees will increase to \$733 per month. This is an increase of \$54 over the 2010 plan year contribution. Depending on which medical plan you select, you may see either an increase or a decrease in your out-of-pocket premiums for 2011. Please review the rates on pages 10-11 carefully and plan to participate in an Annual Change Presentation or Webinar for additional information.

The rates for the new benefit year reflect the ongoing increase in costs for our plan. After the state share increase to \$733 per month, active employees may see contribution changes ranging from a decrease of up to \$17 to an increase of up to \$53 depending on the medical plan you select.

Health Care Reform

As mentioned above, there are a number of changes to our plan with the implementation of the Patient Protection and Affordable Care Act (PPACA) enacted March 23, 2010. The statute includes a number of health-related provisions that take effect over the next four years. The State Plan began implementation of PPACA by providing coverage to dependent children until age 26, removing the pre-existing condition waiting period for dependents 19 and younger, and eliminating some of the maximum annual and lifetime benefit limits.

As we continue to analyze PPACA and as federal regulations become final, we will update you about any necessary changes.

We encourage you to review the booklet carefully so that you may make informed choices for your benefits. Please be sure to review the medical plan rates and the network provider information for each plan. This will assist you in choosing the medical plan that best fits you and your family's needs while helping to reduce your out-of-pocket expenses.

Please remember that the deadline for submitting benefit changes for 2011 is October 27, 2010.

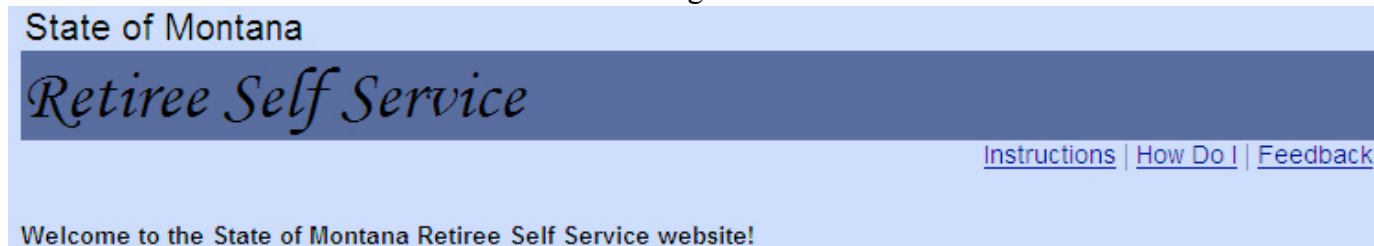
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Retiree Online Access to Make 2011 Benefit Elections

Registration Instructions

1. Go to the Retiree Self Service Website at emine.mt.gov/retiree



2. Click the [Create an ePass account](#) link to obtain a username and password.

If you have already registered and have a valid username and password, click on the

- [Login to this service using ePass](#) link and login into the service.*

3. Key in the requested information and create your username and password. Make note of the username and password you select for future use in the space provided below. Click the [Continue](#) button to create your ePass account.

User Name: _____ **Password:** _____ **Email Address:** _____

Please note that if you forget your password or username, we are unable to retrieve or reset it for you. Your password **hint** can be emailed to you to help you remember; however, there is no way to retrieve your username and in order to use the State's Self Service application, you must re-create an ePass account.

4. After the [Continue](#) button is selected, the system will register your username and password with ePass. Click on the [Retiree Self Service](#) link to register the Retiree Self Service application to your ePass Montana account.

5. Next, you will need to register for the Retiree Self Service application. Key in the requested information, and click the [Register](#) button. Remember that all fields are required. Please note that the email address you enter here will be the email address that your electronic benefit confirmation statement will be sent to after you submit your benefit elections.

6. Upon successful registration you will be redirected to a page notifying you that you have successfully registered for Retiree Self Service access.



Click [Sign In](#) to access the Retiree Self Service application.

7. Select the [Benefits](#) link within the Self Service menu.

8. Select the [Benefits Enrollment](#) link.

9. Once you have made your benefit elections and submitted them to the Health Care and Benefits Division, an electronic confirmation statement will be sent to the email address that you registered with listing your elections for your review.



EMPLOYEE BENEFIT ELECTION INSTRUCTIONS

Welcome to the Annual Change period for the 2011 Benefit Plan Year. This is your only opportunity to elect or change certain benefit options for the upcoming year, so please take the time to review this instructional information. The State's comprehensive package of benefits is an important part of employees' compensation, and we want to help employees make the most of their benefits.

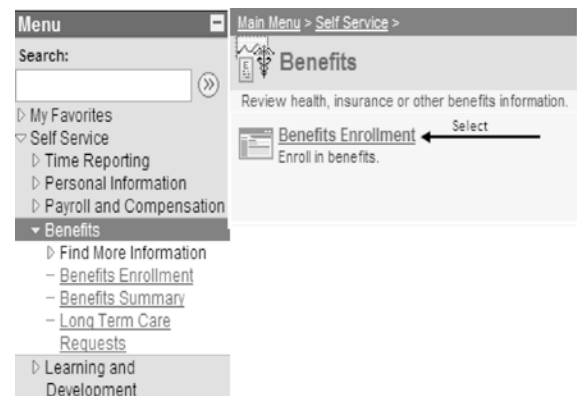
1. Read this booklet.
2. Attend a Benefits Presentation (schedule is listed on page 6-7). Family members are welcome!
3. Decide what benefit options you will elect for the 2011 Benefit Plan Year. You may use the Monthly Benefit Premium Cost worksheet on page 9 to determine your out-of-pocket costs.
4. Submit your 2011 benefit elections by **October 27, 2010** using one of the following methods:

For on-line access from your work location:

1. Log into MINE, <http://mine.mt.gov>
2. Select the Employee Self Service link on the Enterprise Menu
3. Select the Benefits link
4. Select the Benefits Enrollment link

For on-line access from home or other public place:

1. Go to the State Employee Access site at www.mt.gov/employee
2. Select the Employee Self-Service Portal link
3. Log into MINE
4. Select the Employee Self Service link
5. Select the Benefits link
6. Select the Benefits Enrollment link.



Once you have submitted your benefits online, you will receive an automatic e-mail Confirmation Statement verifying your elections.

HELENA BENEFITS PRESENTATION SCHEDULE

EMPLOYEES AND RETIREES:

Date	Time	Location	
Tuesday, September 28	9 - 11 AM 1 - 3 PM	DPHHS Auditorium	
Thursday, September 30	9 - 11 AM 1 - 3 PM	DPHHS Auditorium	
Monday, October 4	9 - 11 AM 1 - 3 PM	DPHHS Auditorium	
Friday, October 8	9 - 11 AM 1 - 3 PM	DPHHS Auditorium	
Wednesday, October 13	9 - 11 AM 1 - 3 PM	DPHHS Auditorium	
Thursday, October 14	9 - 11 AM 1 - 3 PM	DPHHS Auditorium	
Friday, October 15	9 - 11 AM 1 - 3 PM	MDT Auditorium	
Tuesday, October 19	9 - 11 AM 1 - 3 PM	MDT Auditorium	This MetNet is being broadcast to all MDT offices across the state for MDT employees only to call in.

WEBINAR INSTRUCTIONS

To reduce costs, this year's annual change presentations are offered primarily through webinars with limited traditional in-person presentations offered. Now you can learn all you need to know about the 2011 benefits without leaving your office or your home! By attending a live webinar, you will be able to ask questions of the presenter during the presentation by typing in the chat box.

Please follow the instructions below to access a presentation:

1. Sign on to your computer, and go to: www.benefits.mt.gov/annualchange.mcp
2. Review the list of Webinars offered and choose the one that best fits your schedule. Make note of the time and date on your calendar.
3. On the day of the presentation, go to the Website listed in #1 above, and click on the link next to your chosen session.
4. The presentation is "voice over Internet" (VOI), which means you will be able to hear the presentation over your computer speakers AND it doesn't cost a thing! Simply click the "X" in the audio pop-up which requests your phone number when signing into the webinar. If you don't have computer speakers, simply type your phone number (complete with area code) in the audio pop-up when signing in and the webinar conference line will call you.

If you would like to listen to a pre-recorded webinar, you may do so at any time, by going to www.benefits.mt.gov/annualchange.mcp and clicking on Annual Change Presentation for 2011 benefits. If you chose this option, you will not be able to type questions, but you may send any questions that you have to benefitsquestions@mt.gov.

OTHER CITY BENEFITS PRESENTATION SCHEDULE

EMPLOYEES AND RETIREES:

City	Date	Time	Location
Anaconda	Friday, October 1	9 - 11 AM	Community Services Center 118 E 7th
Billings	Tuesday, October 5	9 - 11 AM 1 - 3 PM	South Central Region Office 2525 4th AVE N MDT 424 Morey ST
Please note: You can attend either time and either location in Billings.			
Boulder	Thursday, October 7	9 - 11 AM	MT Development Center Treatment Services/RM
Bozeman	Friday, October 1	9 - 11 AM	MDT Conference RM 907 N Rouse Ave
Butte	Wednesday, September 29	9 - 11 AM 1 - 3 PM	DPHHS 700 Casey ST
Choteau	Tuesday, October 12	9 - 11 AM	No host webinar
Conrad	Tuesday, October 12	9 - 11 AM	No host webinar
Cut Bank	Tuesday, October 12	9 - 11 AM	No host webinar
Dillon	Thursday, October 7	1 - 3 PM	Beaverhead Search & Rescue 1116 HWY 41
Glasgow	Thursday, September 23	9 - 11 AM	Job Service 74 4th ST N
Glendive	Tuesday, October 5	9 - 11 AM	MDT Conference room 503 N River Ave
Great Falls	Monday, September 27*	10 AM - 12 PM	School for Deaf & Blind 3911 Central Ave Basement conference RM
Great Falls	Wednesday, September 29	1 - 3 PM 1 - 3 PM	Cascade Co OPA 201 1st ST S, STE 1 CFS 2300 12th AVE S, STE 211
Havre	Thursday, October 7	1 - 3 PM	Hill County Library 402 3rd ST
Kalispell	Thursday, September 23	9 - 11 AM 1 - 3 PM	MDT 85 5th Ave EN
Lewistown	Wednesday, October 6	9 - 11 AM	Lewistown Library 701 W Main
Libby	Tuesday, October 5	9 - 11 AM	Libby Library 220 W 6th ST
Miles City	Wednesday, October 6	9 - 11 AM	MDT 217 N 4th
Missoula	Monday, October 18	9 - 11 AM 1 - 3 PM	Job Service 539 S 3rd ST W
Polson	Monday, September 27	9 - 11 AM	Lake County Health Dept 802 Main St
Shelby	Tuesday, October 12	9 - 11 AM	No host webinar
Sidney	Thursday, October 7	1 - 3 PM	Community Services Bldg 1201 W Holly
Warm Springs	Wednesday, September 29	1 - 3 PM	Montana State Hospital 300 Garnet Way/Classroom

***Live presentation with a Hearing Impaired Interpreter**

If auxiliary aids/equipment are needed, call 1-800-287-8266 or TDD relay at 1-800-253-4091 one week prior to presentation.

GLOSSARY

Allowable Charges

A set dollar allowance for procedures/services that are covered by the plan.

Benefit Year/Plan Year

The period starting January 1 and ending December 31 of each year.

Certification/Pre-certification

A determination by the appropriate medical plan administrator that a specific service – such as an inpatient hospital stay – is medically necessary. Pre-certification is done in advance of a non-emergency admission by contacting the plan administrator.

Coinsurance

A percentage of allowable and covered charges that a member is responsible for paying, after paying any applicable deductible. The medical plan pays the remaining allowable charges.

Copayment

A fixed dollar amount for allowable and covered charges that a member is responsible for paying. The medical plan pays the remaining allowable charges. This type of cost-sharing method is typically used by managed care medical plans.

Covered Charges

Charges for medical services that are determined to be medically necessary and are eligible for payment under a medical insurance plan.

Deductible

A set dollar amount that a member and family must pay before the medical plan begins to share the costs. The deductible applies to the plan year January 1 to December 31, regardless of hire date.

In-network Providers

Providers who contract with a managed care plan to manage the delivery of care for plan members.

Joint Core

An option that is available when both spouses are eligible state employees and have eligible dependents on their coverage. Spouses and children have only one family deductible and one family out-of-pocket maximum and may have a slightly lower premium than enrolling separately.

Managed Care Medical Plan

Plans that offer first dollar coverage for services such as office visits that are exempt from deductible. These plans also provide differing levels of benefits for in-network and out-of-network providers.

Out-of-network Provider

Any provider who renders services to a managed care member but is not a participant in the plan's network.

Out-of-pocket Maximum

The maximum dollar amount of any coinsurance that a member or family must pay in a plan year. Once the out-of-pocket maximum has been paid, the member or family is not responsible for paying any further allowable charges for the remainder of the benefit year. The out-of-pocket maximum does not include deductibles or copayments. The out-of-pocket maximum applies to the plan year January 1 to December 31, regardless of hire date.

Participating Provider

A provider who has a contract with the plan administrator to accept allowable charges as payment in full.

Prior Authorization

A process that determines whether a proposed service, medication, supply, or on-going treatment is covered.

URx

A prescription drug management program developed by the State of Montana for all plan members.

MONTHLY OUT-OF-POCKET BENEFIT PREMIUM COSTS

STATE CONTRIBUTION FOR 2011

ACTIVE EMPLOYEES	\$ 733.00 (a)
RETIREES	\$ 0.00 (a)

CORE BENEFITS

MEDICAL PLAN (See rates on pages 10 & 11)	CHOOSE ONE	New West: \$ _____ (b)
		Blue Choice: \$ _____ (b)
		Traditional: \$ _____ (b)
DENTAL PLAN (See rates on page 21)		\$ _____ (c)
BASIC LIFE INSURANCE OF \$14,000 (Page 29 – Retirees, please see eligibility section)		\$ 2.10 (d)

TOTAL CORE BENEFITS PREMIUM Add lines b, c, and d = \$ _____ (e)

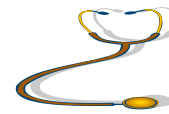
OPTIONAL BENEFITS (*Retirees are only eligible for Long Term Care and Vision in this section)

FLEXIBLE SPENDING ACCOUNTS (Page 26 - 27)	Medical FSA	\$ _____ (f)
	Dependent Care FSA	\$ _____ (g)
	Fee	\$ 2.26 (h)
*VISION PLAN (See Rates on Page 22)		\$ _____ (i)
LIFE INSURANCE (See rates on page 29)	Dependent Life for \$.52 (\$2,000/spouse; \$1,000/child)	\$ _____ (j)
	Optional Employee Life (Age rate x every \$1,000 of coverage)	\$ _____ (k)
	Supplemental Spouse (Age rate x every \$1,000 of coverage)	\$ _____ (l)
Accidental Death & Dismemberment (\$.020 or \$.030 (with dependents) x every \$1,000 of coverage)		\$ _____ (m)
LONG TERM DISABILITY (See Rates on Page 30)		\$ _____ (n)
*LONG TERM CARE (See Rates on Pages 31 - 33)		\$ _____ (o)
OPTIONAL BENEFITS PREMIUM	Add lines f, g, h, i, j, k, l, m, n, and o =	\$ _____ (p)

TOTAL MONTHLY OUT-OF-POCKET COSTS FOR 2011 BENEFITS

CORE BENEFITS	Enter amount from line e	\$ _____ (q)
OPTIONAL BENEFITS	Enter amount from line p	\$ _____ (r)
TOTAL BENEFITS	Add lines q and r	\$ _____ (s)
STATE CONTRIBUTION	Enter amount from line a	\$ 733.00 (t)
WELLNESS DISCOUNT+		\$ _____ (u)
+If you attended a 2010 Health Screening, enter \$5, if you AND a dependent attended a screening, enter \$10		
TOTAL MONTHLY OUT-OF-POCKET COSTS FOR 2011 BENEFITS	Subtract line t and u from s	\$ _____

ANNUAL SCHEDULE OF BENEFITS



MEDICAL PLAN

Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315
www.bluecrossmontana.com

New West Health Plan • 1-800-290-3657 or 457-2200
www.newwesthealth.com

MEDICAL RATES

Monthly and Per Paycheck Premiums

	New West	Blue Choice	Traditional
Employee	\$682/\$341	\$682/\$341	\$696/\$348
Employee & spouse	\$856/\$428	\$856/\$428	\$870/\$435
Employee & children	\$769/\$385	\$769/\$385	\$783/\$392
Employee & family	\$908/\$454	\$908/\$454	\$922/\$461
Joint Core	\$717/\$359	\$717/\$359	\$730/\$365

DISCLAIMER: The Patient Protection and Affordable Care Act (PPACA) was enacted on March 23, 2010. The United States Departments of Health and Human Services, Labor and Treasury have issued regulations to help entities comply with PPACA. However, additional clarifications to address issues that may arise under these regulations could also be published by the Departments on an on-going manner through administrative guidance possibly in another form than a regulation. Where the statutes or regulations were not clear regarding benefits, the State of Montana made a reasonable interpretation of the Act and made a good faith effort to comply with the statutes and regulations. The State of Montana reserves the right to alter provisions of this document and its plan in order to comply with applicable law.

MEDICAL PLAN COSTS

Annual Deductible

(Applies to all services unless noted or a copayment is indicated.)

(The deductible applies for the plan year, January 1 to December 31 regardless of hire date)

Coinsurance Percentages (% of allowed charges member pays)

General

Preferred Facility Services *(See pages 40-41 for a list of preferred/non-preferred facilities)*

Non-Preferred Facility Services

Annual Out-of-Pocket Maximums

(Maximum coinsurance paid in the year; excludes deductibles and copayments)

(The out-of-pocket maximum is applied for the plan year regardless of hire date)

You pay the deductible and coinsurance on allowable charges (see glossary on page 8).

MEDICAL PLAN COSTS

Hospital Inpatient Services*

*Pre-certification of non-emergency inpatient hospitalization is strongly recommended & required by some plans - see plan descriptions.

Room Charges*

Ancillary Services

Surgical Services

Hospital Outpatient and Surgical Center Services

BENEFIT YEAR 2011

NON-MEDICARE MEDICAL RATES (under age 65)

Monthly Premiums	New West	Blue Choice	Traditional
Retiree	\$691	\$691	\$705
Retiree & spouse	\$944	\$944	\$958
Retiree & children	\$830	\$830	\$844
Retiree & family	\$967	\$967	\$982
Retiree & Medicare spouse	\$795	\$795	\$810
Retiree & Medicare spouse and child	\$845	\$845	\$859

MEDICARE MEDICAL RATES (age 65+)

Monthly Premiums	New West	Blue Choice	Traditional
Medicare retiree	\$285	\$285	\$291
Medicare retiree & spouse	\$566	\$566	\$578
Medicare retiree & children	\$466	\$466	\$475
Medicare retiree & family	\$592	\$592	\$604
Medicare retiree & Medicare spouse	\$496	\$496	\$506
Medicare retiree & Medicare spouse & family	\$507	\$507	\$518

TRADITIONAL PLAN

Administered by BCBS of MT

MANAGED CARE BENEFIT PLANS BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT NEW WEST - Administered by New West Health Plan

Benefits

\$600/Member
\$1,800/Family

25%
20%
35%

Average of \$2,500/Member

Average of \$5,625/Family

In-Network Benefits

\$425/Member
\$850/Family

25%

\$2,000/Member
\$4,500/Family

Out-of-Network Benefits

Separate \$650/Member
Separate \$1,300/Family

35%

Separate \$3,500/Member
Separate \$8,000/Family

Member Coinsurance:

20% - 35%

20% - 35%

20% - 35%

20% - 35%

Member Coinsurance/Copayment:

25%

25%

25%

25%

Member Coinsurance:

35%

35%

35%

35%

ANNUAL SCHEDULE OF BENEFITS

MEDICAL PLAN SERVICES

Physician/Professional Services (not listed elsewhere)

Office Visits

Inpatient Physician Services

Lab/Diagnostic/Injectables/Miscellaneous Charges

Emergency Services

Ambulance Services for Medical Emergency

Emergency Room (*If there is an inpatient emergency admission, see plan description for authorizing follow up care.*)

Hospital Charges

Professional/Ancillary Charges

Urgent Care Services

Facility/Professional Charges

Ancillary - Lab/Diagnostic/Surgical Charges

Maternity Services

Hospital Charges

Physician Charges (including delivery, pre and post-natal office visits) and lab charges

Ultrasounds

Routine Newborn Care

Inpatient Hospital Charges

Preventive Services (see plan descriptions for what services are covered and when)

Adult Exams and Tests

Adult Immunizations (such as Pneumonia and Flu)

Allergy Shots

Well Child Checkups and Immunizations

Mental Health Services

Inpatient Services

Max: One inpatient day may be exchanged for two partial hospital days.

Outpatient Services

Please see page 24 for additional EAP benefit

BENEFIT YEAR 2011

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TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
25% (no deductible for first two non-routine office visits)	\$15/visit (covers office visit charges only)	35%
25%	25%	35%
25%	25% (no deductible on injectables without an office visit)	35%
25%	\$200 copay	\$200 copay
20%-35%	\$150/visit for facility charges only (waived if inpatient hospital or out patient surgery, coinsurance applies)	\$150/visit for facility charges only (waived if inpatient hospital or out patient surgery, coinsurance applies)
25%	25%	25%
25%	\$35/visit	\$35/visit
25%	25%	25%
20% - 35%	25%	35%
25%	0% (no deductible) with enrollment in prenatal program in first trimester of pregnancy; 25% otherwise	35%
25%	25% (waived on first ultrasound if member enrolls in prenatal program as described above)	35%
20% - 35% (no deductible)	25% (no deductible)	35%
25% (no deductible) Max: 2 bone density tests/lifetime Refer to Summary plan document for covered preventative benefits	\$15/visit (including specified labs) Refer to Summary plan document for covered preventative benefits	35% Refer to Summary plan document for covered preventative benefits
Flu and Pneumonia only (no deductible)	\$15 with office visit	
25% (no deductible)	25% (no deductible) without office visit up to \$10	35%
25% (no deductible)	\$15 with office visit 25% (no deductible) without office visit up to \$10	35%
25% (no deductible) 0% (no deductible for County Health Department through age 7)	\$15/visit Max: Schedule recommended by US Department of Health & Human Services	35%
20% - 35% Max: 21 days (No max for severe conditions)	25% Max: 21 days/yr (No max for severe conditions)	35% Max: 21 days/yr (No max for severe conditions)
25% Max: 40 visits/yr (No max for severe conditions)	\$15/visit Max: 30 visits/yr (No max for severe conditions)	35% Max: 30 visits/yr (No max for severe conditions)

ANNUAL SCHEDULE OF BENEFITS

MEDICAL PLAN SERVICES

Chemical Dependency Services

Inpatient Services*

(Inpatient services must be certified. Pre-certification is strongly recommended.)

Outpatient Services

Please see page 24 for additional EAP benefit

Rehabilitative Services - Physical, Occupational, Cardiac, Pulmonary, and Speech Therapy

Inpatient Services

Outpatient Services

Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

Extended Care Services

Home Health Care (Pre-authorization recommended)

Hospice

Skilled Nursing (Pre-authorization recommended)

Miscellaneous Services

Disease Process Education & Dietary/Nutritional Counseling

Durable Medical Equipment, Appliances, and Orthotics *(Prior authorization required for amounts >\$1,000)*

PKU Supplies

Obesity Management *(All plans require prior authorization)*

TMJ Treatment *(All plans require prior authorization)*

Infertility Treatment *(All plans require prior authorization)*

Biological infertility only

Bariatric Benefit *(Requires prior authorization)*

Organ Transplants (Precertification, preauthorization and case management is required.)

Transplant Services (including a \$5,000 maximum for out of state travel)

BENEFIT YEAR 2011

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
20%-35% 10 day Max additional must be preauthorized	25% 10 day Max additional must be preauthorized	35% 10 day Max additional must be preauthorized
25% 40 visit Maximum	\$15/visit 40 visit Maximum	35% 40 visit Maximum
20% - 35% Max: 60 days/yr	25% Max: 60 days/yr	35% Max: 60 days/yr
20% - 35% 30 visit maximum (additional visits may be available with prior authorization)	\$15/visit Max: 30 visits/yr	35% Max: 30 visits/yr
25% (maximum payable \$30/visit) Max: 25 visits in any combination	Not covered	Not covered
25% (maximum payable \$30/visit) Max: 25 visits in any combination	Not covered	Not covered
25% (maximum payable \$30/visit) Max: 25 visits in any combination	\$15/visit Max: 20 visits/yr	35% Max: 20 visits/yr
25% Max: 70 days/yr	\$15/visit Max: 30 visits/yr	35% Max: 30 visits/yr
25% (20% - 35% if hospital-based) Max: 6 months	25% Max: 6 months	35% Max: 6 months
25% (20% - 35% if hospital-based) Max: 70 days/yr	25% Max: 30 days/yr	35% Max: 30 days/yr
20% - 35% Max: \$250/yr	0% (no deductible) Max: \$250/yr	35% Max: \$250/yr
25% maximum payable Max \$100 for foot orthotics (per foot)	25% (Not applied to out-of-pocket max) Max payable \$100 for foot orthotics (per foot)	40% (not applied to out-of-pocket max) Max payable \$100 for foot orthotics (per foot)
25%	25% (no deductible)	35%
25%	25% non-surgical only	Not covered
25%	25% surgical only	Not covered
25% 1 in-vitro attempt per lifetime	25% Max: 3 artificial inseminations/lifetime	Not covered
25%	Not covered	Not covered
25%	25%	Not covered

MEDICAL INSURANCE PLANS - 2011



Administered by:

Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315 • www.bluecrossmontana.com

New West Health Plan • 1-800-290-3657 or 457-2200 • www.newwesthealth.com

WHO IS ELIGIBLE?

Employees, Legislators, Retirees, COBRA members and their dependents (spouse, domestic partner, children) are eligible for the medical plan. Employees are required to be enrolled in medical coverage unless they waive the entire benefit package. For more information about dependent eligibility, see page 18.



CLICK ON IT!

Learn more about the participating providers by visiting the plan's web sites at:

www.bluecrossmontana.com

www.newwesthealth.com

HOW TO DECIDE THE RIGHT PLAN FOR YOU

1. Read about each plan in the General Information section on this page.
2. Review/compare each plan's costs, deductibles and services in the Schedule of Benefits starting on page 10 or through the SOME information resource available on the MINE or www.benefits.mt.gov.
3. Review your typical health care needs compared with the structure of the plans.
4. If you are considering a managed care plan, review the Managed Care Areas section on pages 37-39.
5. Determine which plan will work best for your personal situation.

GENERAL INFORMATION

The State of Montana offers an indemnity insurance plan and two managed care plans to choose from:

- Traditional Indemnity Plan
- Blue Choice Plan
- New West Health Plan

TRADITIONAL PLAN

The Traditional Indemnity Plan is administered by Blue Cross and Blue Shield of Montana (BCBS MT), which processes claims and payments and provides customer service and notices to members in the form of an Explanation of Benefits (EOB). BCBS MT also contracts with health care providers to offer plan members a provider network — providers who have agreed to accept certain plan allowances.

How The Plan Works

Plan members obtain medical services from a covered health care provider. If the provider is a BCBS MT provider, they will submit a claim for the plan member. BCBS MT will then process the claim and send an EOB to the plan member, indicating their payment responsibilities (deductible and/or coinsurance costs) to the provider. The Plan then pays the remaining allowable charges, which the provider accepts as full payment. Please verify a provider is currently participating by calling BCBS MT or checking their website shown above.

If the provider is not a BCBS MT provider, you may be required to pay the entire fee and file a claim for reimbursement. There may be charges above the allowable fee that you will have to pay.

Preferred Facility Services

Plan members may obtain covered medical services from any covered hospital. However, certain hospitals and surgical centers offer services for members on the Traditional Plan that are subject to lower coinsurance rates. Please refer to the Participating Facilities section on page 40 for a list of these facilities. For your protection, it is strongly recommended to pre-certify all inpatient hospital services by calling your plan's customer service phone number, listed at the top of this page.

Out-of-State Services

The Blue Card Program lets plan members tap into BCBS plan networks in other states. If the out-of-state BCBS plan includes "hold harmless" provisions, the member will not be responsible for balances above the allowable amount.

MANAGED CARE PLANS

The Blue Choice and New West Health Plans are managed care plans offered through the Montana Association of Health

Care Purchasers, a purchasing pool of which the State is a member. The plans generally provide the same package of benefits, but there are differences in providers and requirements for receiving services.

How They Work

The benefits of managed care plans depend on the health care provider the member uses. When a network provider is used, the in-network benefits apply. When an out-of-network provider is used, out-of-network benefits apply (unless a required plan authorization is obtained).

In-Network Benefits

Anytime a network provider is used, the in-network (highest level of benefit) is applied. For a complete listing of all in-network providers including specialists, check the plan administrator's website or call their customer service number listed at the top of this page. An authorization is not required for the plan member to see an in-network specialist. Plan authorizations are required to see an out-of-network specialist and receive the plan's in-network benefits.

Out-of-Network Benefits

When plan members obtain services from providers who are not part of the plan's network, without a required authorization, costs will be more because a separate and

higher deductible, a higher coinsurance rate, and a separate out-of-pocket maximum apply.

To obtain an authorization to see an out-of-network provider from New West or Blue Choice plans, the member **MUST** contact the plan administrator directly.

Major Plan Differences

The major difference in the managed care plans are the participating providers. Check which providers participate by visiting the plan websites listed on page 16.

Out-of-State Services

Plan members may receive in-network benefits for medical services in other states for a medical emergency. For non-emergency services out-of-state, please contact your plan administrator for specific provider network information.

SERVICE AREAS

The Traditional Plan is available to members living anywhere in Montana or throughout the world. The plan includes services of any covered providers. However, providers who are not BCBS member providers may charge more for a service than the plan allows, leaving you responsible for paying the difference.

The managed care plans – Blue Choice and New West Health Plan are available to members living in certain areas in Montana. Please see pages 37-39 for a complete listing of covered zip codes for each plan.

Blue Choice

This plan is available in most of Western Montana and many other towns including Bozeman, Billings, Great Falls, and Havre.

New West Health Plan

This plan is available in most of Western Montana and many other towns including Bozeman, Billings, Great Falls, Havre, Libby, Miles City and Lewistown.

QUESTIONS

For specific questions related to how the plan works, network issues or service areas, please contact the plan administrators at the numbers listed on page 16.

QUALITY CARE CHOICES

The Quality Care Choices (QCC) program offers focused disease management and case management services by Health Care & Benefits Division nurse case managers and contracted vendors. These professionals work with State plan members identified by specific disease states, the participant's medical providers and families to provide medically appropriate, effective and cost efficient care. Participants are identified for these programs by meeting one of the following criteria:

- chronic health care needs that may be reduced through participation in one of the disease management program listed;
- a need for wellness promotion or health coaching;
- having significant medical risks; or
- receiving treatment for a catastrophic illness or injury.

The State of Montana health plan offers the following disease management programs to its participants to assist in managing their care:

Infusion Services Program

The State Plan has partnered with **Walgreens OptionCare** to offer an infusion services program. This program is available to plan members needing prescription drugs administered by infusion therapy (Synagis, Remicade, Tysabri, Orencia, Reclast, Boniva, Immune Globulin – IVIG, Actemra, Rituxan, Cerezyme, Privigen, Benefix). For more information, contact Walgreens OptionCare at 1-800-449-1256 or Health Care & Benefits Division at 1-800-287-8266, 444-7462 or visit our website at www.benefits.mt.gov.

Oncology Management Program

The State Plan has partnered with the **Billings Clinic** to offer a pilot oncology/cancer treatment program available to plan members requiring these types of services and live in certain designated geographic areas of Montana. For more information, contact the Billings Clinic at 1-877-537-6421, Health Care & Benefits Division at 1-800-287-8266, 444-7462 or visit our website at www.benefits.mt.gov.

If you currently seek services as listed above and agree to participate in the Quality Care Choices program, you may receive a majority of your care for NO OUT-OF-POCKET COST. The plan may WAIVE your copayment, coinsurance and deductibles on services received as part of QCC. Services ordered by the QCC, however, rendered by another provider will be subject to your regular benefits.

ALLOWED DEPENDENT CHANGES & ELIGIBILITY INFORMATION

Administered by the Health Care and Benefits Division
1-800-287-8266 or 444-7462 • www.benefits.mt.gov

ALLOWED DEPENDENT CHANGES DURING ANNUAL CHANGE

During Annual Change, members can only add dependents to the dental and vision plans. To enroll additional dependents in these plans, provide the requested information on your dependent (s) and check the box next to their name.

The deadline to make allowed dependent changes as well as other plan changes during Annual Change for 2011 is **October 27, 2010**.

DELETING DEPENDENTS

You may delete dependent coverage during this period. Once a dependent is removed from the plan, they may not be re-enrolled without a qualifying event (described on this page).

The deadline to delete dependents and to make all other plan changes for 2011 is **October 27, 2010**.

DECLARING DEPENDENT'S TAX STATUS

A *Declaration of Tax Status* form will be sent to all employees who have added a spouse or domestic partner to dental or vision during the Annual Change period. This form must be completed and returned immediately to apply the appropriate tax treatment to your spouse or domestic partner. Failure to return the form will result in your spouse or domestic partner being defaulted to a non-qualified status. For more information, check out the Declaration of Tax Status page on the Health Care and Benefits Division website at www.benefits.mt.gov.

For employees who previously completed a *Declaration of Tax Status* form on a spouse or domestic partner, ensure the status is still correct. You can determine the current tax status of your spouse or domestic partner by reviewing your pay advice and looking for a 'non qual' premium description. If changes are needed, please complete and return a new *Declaration of Tax Status* form (available on-line at www.benefits.mt.gov).

ENROLLING DEPENDENTS AFTER ANNUAL CHANGE

After the Annual Change period, dependent coverage enrollment is only allowed during these circumstances (referred to as qualifying events):

- within 63 days of becoming a dependent (through marriage, or court-ordered support/custody/legal guardianship);
- within 63 days of losing eligibility (not cancellation) for other group coverage;
- within 63 days of losing an employer's contribution toward other group coverage, sustaining a major increase in out-of-pocket costs, or losing benefits;
- within 63 days after the 31-day automatic coverage period (94 days from birth) after birth or adoption.

Notify your Agency Personnel when one of the above circumstances occurs (within the specified time-frames) to enroll dependents.

If you have questions regarding your specific situation, please call us at the number above or check out the plan rules described in the Summary Plan Document available on-line at www.benefits.mt.gov.

ELIGIBLE DEPENDENTS DEFINED

Eligible dependents include:

1. The eligible employee's lawful spouse or declared domestic partner (Declaration of Domestic Partnership forms may be found on the Health Care and Benefits Division website at www.benefits.mt.gov); and
2. The eligible employee's dependent children who are under age 26 and not in full-time active military service.

It is the responsibility of the member to remove any dependents who cease to be eligible. Failure to do so will result in the member being held responsible for repayment of any claims dollars paid out for ineligible dependents.

QUESTIONS?

There are many ways to contact Health Care and Benefits Division
Email: benefitsquestions@mt.gov
Web: www.benefits.mt.gov
Phone: 1-800-287-8266 or 444-7462 in Helena.

PRESCRIPTION DRUG PLAN - 2011

URx Powered by MedImpact• 1-888-648-6764• www.urx.mt.gov



URx Prescription Drug Program

URx is designed to:

- Improve your overall health
- Put you and your doctor in control of your health care decisions
- Help you reduce your out-of-pocket costs for prescription drugs

THERE IS NO DEDUCTIBLE!

FOR PRESCRIPTION DRUGS IN 2011

OUT-OF-POCKET MAXIMUMS FOR 2011

Individual: \$1,650/year
Family: \$3,300/year

MedImpact is the pharmacy benefit administrator. Contact MedImpact for pharmacy related questions at **1-888-648-6764**.

ASK A PHARMACIST

For questions concerning how a drug works, interacts with other prescription medications, or for assistance locating an alternative for a D or F medication, contact the **ASK-a-Pharmacist** program, 1-888-5-ASK-URx (527-5879).

GENERAL INFORMATION

WHAT IS URX?

URx is a prescription drug management program developed by the State of Montana. **URx** uses the prescription process as a mechanism to manage overall care of a member by focusing on producing better clinical outcomes by making sure members get the best drug to treat their condition.

HOW DOES URX WORK?

One component of the **URx** program is the Pharmacy & Therapeutics Committee (PTAC). Under the State of Montana's oversight, this committee is responsible for evaluating drugs based on their proven clinical results. The PTAC committee is charged with developing the formulary (the list of preferred drugs covered by the plan) that will make the most effective drugs the least expensive to the member, regardless of the drug's actual cost.

With **URx** there will be no deductible and Class A, B, and C prescriptions will accumulate towards an out-of-pocket maximum.

WHO IS ELIGIBLE?

The Prescription Drug Plan is a benefit for all State Employees, Legislators, Retirees, and COBRA members and their eligible dependents. Any member enrolled in a medical insurance plan will automatically receive this plan. There is no separate premium for this plan.

PRESCRIPTION OPTIONS

Prescription drugs may be obtained through the plan at either a local pharmacy (30 day supply) or a mail-order pharmacy (90 day supply). Members who use maintenance medications can experience significant savings by utilizing a mail order pharmacy. You may obtain up to a 30-day supply of all covered prescriptions from a local pharmacy.

Access to the formulary drug listings can be found at www.benefits.mt.gov, or by calling Health Care and Benefits Division at 1-800-287-8266 or 444-7462.

MedVantx, 1-877-870-MONT[6668] and **Ridgeway Mail Order Pharmacy of Montana**, 1-800-630-3214 will administer

the mail-order drug program. MedVantx and Ridgeway will provide mail-order pharmacy services to plan members, based on **URx** pricing and plan design.

There are some medications that are not allowed through mail order. They include sleeping medications, narcotics of any type, muscle relaxers, antibiotics, and controlled substances.

SPECIALITY PHARMACY

Diplomat Specialty Pharmacy, 1-877-319-6337, is the administrator of the specialty pharmacy program. Diplomat will provide assistance and resources to members who are prescribed high dollar oral, intravenous, or injectable medications.

PRIOR AUTHORIZATIONS

Some drugs require prior or special authorization. Contact MedImpact at 1-888-648-6764 to inquire if this may apply to your prescription.



URx Drug Classification (Based on medical evidence of impact to health and overall net cost)	Drug Class	Deductible	Retail Rx (30-day supply)	Mail Rx (90-day supply)
Excellent level of value based on best medical evidence, best opportunity for improved health outcomes via disease management, and best overall net cost.	Class A	\$0	\$0 Copayment †	\$0 Copayment †
High level of value based on medical evidence of outcomes and lower overall net cost savings. Includes generic and brand drugs compared to higher cost brand name counterparts	Class B	\$0	\$15 Copayment †	\$30 Copayment †
Good level of value based on fair medical evidence grading, but displaying higher overall net cost relative to generic counterparts and less expensive brand name drug or clinical alternatives.	Class C	\$0	\$40 Copayment †	\$80 Copayment †
Lower level of value based on evidence of outcomes relative to other clinical alternatives. Generally have much higher overall net costs. [Coinsurance is calculated on the discounted cost of drugs. Discounts have been negotiated for most drugs purchased through URx.]	Class D	\$0	50% Coinsurance †* (You will pay half of the discounted price)	50% Coinsurance †* (You will pay half of the discounted price)
These drugs have the lowest level of value (based on clinical evidence) or the highest overall net cost in relation to generic or other brand alternatives. Class F drugs may also include drugs that were not previously covered, allowing members to purchase them at a substantial discount. [Coinsurance is calculated on the discounted cost of drugs. Discounts have been negotiated for most drugs purchased through URx.]	Class F	\$0	100% Coinsurance †* (You will pay 100% of the discounted price)	100% Coinsurance †* (You will pay 100% of the discounted price)
Specialty Drugs	Drug Class	Deductible	Retail Rx (30-day supply)	Mail Rx (90-day supply)
If you take a specialty drug, you are encouraged to use the URx Specialty Pharmacy program to qualify for a \$150 copayment. If you fill your prescription at a retail pharmacy, you will have to pay 50% coinsurance. Specialty drugs are not covered through the mail-order program. Certain preferred specialty drugs will be available for a \$0 Co-payment through the URx Specialty Pharmacy program.	Class S	\$0	50% Coinsurance †* if purchased through standard retail pharmacy	Not Covered

† A **copayment** is a flat dollar amount you pay for Rx services. **Coinsurance** is a percentage of the total discounted prices you pay for Rx services. Coinsurance is calculated on the discounted cost of drugs. Discounts have been negotiated for most drugs purchased through URx.

* The amounts you pay in these categories do not count toward your annual out-of-pocket prescription maximum.

WHAT CLASS ARE YOU IN?

Most people don't realize that just because a drug costs more... doesn't mean it's better. Drug manufacturers spend billions of dollars each year on advertising - so if you see six commercials for a particular drug, that drug may cost you a lot! Currently the State of Montana plan spends more on prescription drugs than on doctor visits!

HOW DO I DETERMINE WHAT CLASS MY DRUG IS?

You can look up which class your drug is

in at www.urx.mt.gov or by calling Health Care and Benefits. If you are unsatisfied with the class or the 'grade' your drugs makes, other therapeutically equivalent drugs that are more cost effective will be displayed that you can discuss with your physician.

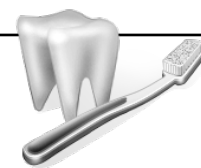
We encourage you to take this information to your physician to determine if you are able to use the therapeutically equivalent drug.

If you are unable to take an alternative medication, contact Health Care Benefits Division for plan exception questions.

WHAT DOES IT MEAN THAT MOST DRUGS ARE COVERED?

The State of Montana's Pharmacy Benefit Administrator negotiates discounts with pharmaceutical companies. These discounts will be passed on to you regardless of the class of your drug. Most drugs, including those that were formerly not covered, will have a discount. This savings will be passed on to you as a member of the State of Montana benefit plan.

DENTAL PLAN - 2011



Administered by Blue Cross/Blue Shield of Montana
1-800-423-0805 or 444-8315 • www.bluecrossmontana.com

Deductible

\$50/Member
\$150/Family

Monthly and Per Paycheck Premiums

Member only	\$34.90/\$17.45
Member and spouse	\$53.12/\$26.56
Member and children	\$51.58/\$25.79
Member and family	\$59.36/\$29.68
Joint Core	\$40.74/\$20.37

Covered Services

Type A: Preventive and Diagnostic

Plan Pays

• 100%**

Limitations/Maximums

- One full-mouth X-ray or series in any 36-month period
- One set of supplementary bitewing X-rays in any 180-day period
- Two exams and/or cleanings in any benefit year (Fluoride application covered through age 16)
- No deductible or yearly dollar maximum apply

Type B: Fillings, Oral Surgery, etc.

• 80%**

- Subject to \$50 combined (with type C) deductible
- Subject to \$1,200 combined (with type C) yearly maximum

Type C: Dentures, Bridges, etc.

• 50%**

- Subject to \$50 combined (with type B) deductible
- Subject to \$1,200 combined (with type B) yearly maximum
- Dental sealants – limited to covered dependents under age 16 – may be applied to molars once per tooth per lifetime

**Of allowable charges.

GENERAL INFORMATION

WHO IS ELIGIBLE?

Employees, Legislators, Retirees, and COBRA members and their dependents are required to be enrolled in dental coverage unless they waive the entire benefit package. Medicare eligible retirees have the option to continue dental or waive. Members also choose which dependents to cover. During the Annual Change period, you may add and/or delete dependents from the dental plan.

SERVICE TYPES

Dental plan benefits are paid differently depending on the type of service received.

There is a \$50 per member, \$150 family deductible for Type B & C services only. The deductible does not apply to Type A preventive services.

Each member and dependent has a maximum yearly benefit of \$1,200 for Type B & C services only.

If you use a Blue Cross and Blue Shield participating dentist, you will not be responsible for costs beyond the allowable charges for covered services.

Type A Services

The Dental Plan pays 100 percent of the allowable charges for Type A Services (not subject to deductible):

1. Diagnostic – Dental X-rays required in connection with the diagnosis of a specified condition requiring treatment. Dental X-rays are limited to one full mouth X-ray or series in any 36-month period and not more than two sets of supplementary bitewing X-rays in any benefit year.

2. Preventive – Oral examination, including prophylaxis (cleaning) and topical application of fluoride for dependent children under 16 years of age, but *not more than two examinations and/or applications in any benefit year*.

3. Unscheduled minor emergency treatment to relieve pain.

Type B Services

The Dental Plan pays 80 percent of the allowable charges (after deductible) for Type B Services:

1. Passive space maintainers
2. Extractions
3. Fillings
4. Mucogingivoplastic surgery

5. Endodontics

6. Periodontics

7. Oral surgery

Type C Services

The Dental Plan pays 50 percent of the allowable charges (after deductible) for Type C Services:

1. Crowns, bridge abutments (bridge retainers crowns), inlays, onlays, pontics and gold and porcelain fillings. Replacement of crowns is limited to once every five years.

2. Bridges.

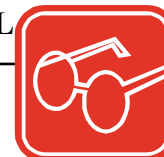
3. Repair and rebasing of existing dentures.

4. Initial and replacement dentures, limited to no more than one set of replacement dentures in any 5-year period.

5. Up to \$1,500 per person, per lifetime for dental implants while under the plan. This maximum is separate from the yearly maximum.

6. Dental sealants, limited to covered dependents under age 16 applied to molars once per tooth per lifetime. Repair and resealing are not covered.

VISION PLAN - 2011 Enrollment is NOT automatic! YOU MUST RE-ENROLL



Administered by EyeMed Vision Care underwritten by Fidelity Security Life Insurance Co.

1-866-723-0513 Fax: 1-866-293-7373

www.enrollwiththeyemed.com/access (prior to enrolling)

www.eyemedvisioncare.com (after enrolling)

Monthly and Per Paycheck Premiums

Member only	\$ 7.64/\$ 3.82
Member and spouse	\$14.42/\$ 7.21
Member and children	\$15.18/\$ 7.59
Member and family	\$22.26/\$11.13

Covered Services	Frequency	Coverage from an EyeMed Doctor	Out of Network Reimbursement	Rural OON Reimbursement **
Eye Exam	12 months	\$10 copay	\$45 allowance	Up to \$85
Frames	24 months	\$125 allowance with 20% discount > \$125	\$52 allowance	Up to \$100
Standard Lenses (plastic single vision, bifocal & trifocal)	12 months	\$20 copay	\$45 allowance - single vision \$55 allowance - bifocal \$65 allowance - trifocal	Up to \$45 Up to \$55 Up to \$65
Standard Progressive (add to bifocal)		\$85 copay	\$55 allowance-progressive	Up to \$55
UV coating		\$15 copay	N/A	N/A
Tint (solid and gradient)		\$15 copay	N/A	N/A
Scratch Resistance (standard)		\$15 copay	N/A	N/A
Polycarbonate (standard)		\$40 copay	N/A	N/A
Anti-Reflective Coating (standard)		\$45 copay	N/A	N/A
Other Add-ons and Services		20% off retail price	N/A	N/A
Contact Lenses	12 months			
Conventional		\$125 allowance with 15% discount >\$125	\$95 allowance	\$100 allowance
(Contact lenses are in lieu of eyeglass lenses)		\$125 allowance plus the balance over \$125	\$95 allowance	\$100 allowance
Disposable				
Medically Necessary Contacts*		Paid in full	\$200 allowance	\$200 allowance

*Contact lenses that are required to treat medical or abnormal visual conditions, including but not limited to eye surgery (such as cataract removal), visual perception in the better eye that cannot be corrected to 20/70 through the use of eyeglasses, and certain corneal or other disease of the eye.

**To qualify for the enhanced out-of-network reimbursement, employees who are enrolled on the vision plan and who reside more than 50 miles from the nearest network provider, may receive this level of vision benefit.

GENERAL INFORMATION

WHO IS ELIGIBLE?

Employees, Retirees, Legislators, and COBRA members and their dependents are eligible for this optional benefit.

Using Your EyeMed Benefit

Quality vision care is important to your eye wellness and overall health care. Accessing your EyeMed Vision Care benefit is easy. Simply locate a participating provider, schedule an appointment, present your ID card at the time of service, and the provider will take care of the rest.

Locating your Doctor

Check the on-line provider locator at www.enrollwiththeyemed.com/access for a listing of providers near your zip code. Once enrolled, visit www.eyemedvisioncare.com to view coverage and eligibility information.

Value Added Discounts

Members will receive a 20% discount on items not covered by the plan at Network

Providers, which may not be combined with any other discounts or promotional offers, and the discount **does not apply** to EyeMed professional services or contact lenses.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.

Members receive a 40% discount off a complete pair of eyeglasses purchased and an additional 15% discount off conventional contact lenses once the funded benefit has been used.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. The contact lens benefit allowance is not applicable to this service.

Out-Of-Network Providers

Once enrolled, members can access their out-of-network benefit by:

1) Downloading an Out-of-Network Claim Form from the EyeMed Vision Care website, www.eyemedvisioncare.com, or by calling the Customer Care Center at 1-866-723-0513.

2) Make an appointment with an out-of-network provider you trust as your choice vision care provider.

3) Pay for all services at the point of care and receive an itemized receipt from the provider office.

4) Complete the out-of-network claim form, and submit along with receipts to EyeMed Vision Care's claims department for direct reimbursement.

You may fax your claim form to the fax number above.

WELLNESS PROGRAMS - 2011

Sponsored by the Health Care and Benefits Division, State of Montana Healthy Employee Lifestyle Program (SOMHELP)
1-800-287-8266 or 444-7462 • www.benefits.mt.gov/wellness.mcp



2011 Programs	Cost	Benefits
Health Screenings	Free annually to member and dependents over 18 on health care plan	<ul style="list-style-type: none">• Confidential screenings for glucose, cholesterol, HDL, LDL, & triglycerides• Blood pressure and body mass index
Spring Fitness	Fee varies	<ul style="list-style-type: none">• Team program designed to get people <i>active</i>
Weight Watchers	Fee varies	<ul style="list-style-type: none">• Helps pay for qualifying employees/dependents over 18 to join Weight Watchers with up to \$75 biennial reimbursement
Lunch 'n' Learn Series	Free	<ul style="list-style-type: none">• This educational series offers health information in an informal format

GENERAL INFORMATION

\$5 Discount
off Medical Premium for attending a health screening in 2011. Go to www.benefits.mt.gov/wellness.mcp for more information

HEALTH SCREENINGS

The State of Montana Healthy Employee Lifestyle Program (SOMHELP) offers employees, spouses, and dependents age 18 and over on the medical plan one free health screening each year.

The health screenings provide a valuable way for you to manage your own health, by putting the same health information in your hands year after year. It is an excellent way to establish baselines and follow trends in your personal health and build positive relationships with your health care provider.

With an appointment, health screenings take about 20 minutes. The health screening staff will draw your blood, do a height and weight measurement, calculate your BMI, and take your blood pressure and blood oxygenation. Your blood sample will be used to perform lab tests. The free tests included in the screening are a Lipid Panel, Comprehensive Metabolic Panel, and Complete Blood Count.

LUNCH 'N' LEARN SERIES

Throughout the year, free, educational lunchtime talks are offered by local experts at convenient work-site locations. Suggestions are welcome for future programs and recorded presentations are available on the SOMHELP website.

WEIGHT WATCHERS

The SOMHELP Program will reimburse employees and/or dependents over 18 up to \$75/biennially for successful participation in the areas of weight, attendance, achievement, and exercise.

For more information on program qualifications and reimbursement instructions, call Health Care and Benefits Division or visit www.benefits.mt.gov/weightwatchers.mcp.

SPRING FITNESS

State Employees favorite way to get fit, stay fit, and get fitter! The 8-week program is based on steps taken, but encourages all kinds of physical activity and healthful lifestyles. Fun-Prizes-Health-Nutrition-Team Building. Coming in April 2011!

HUNTER'S CHALLENGE

Fun, Prizes, Motivation, More Successful Backcountry Sporting! The Hunter's Challenge is for anyone who participates in hunting, backpacking or other fall sports and wants a jump start. Participants set a goal, either steps or minutes, of physical activity each day. Members are welcome to participate in one or both challenges. Coming in July 2011!

TOBACCO CESSATION PROGRAM

The State plan has partnered with the Montana Tobacco Quit Line to provide a benefit for those ready to quit using tobacco. This free program provides cessation counseling services and cessation medication for participants in the program. Visit the wellness website for more information.

TAKE CONTROL DIABETES MANAGEMENT PROGRAM

The State Plan has partnered with Take Control to offer a diabetes support and management program. Take Control is available to plan members who have diabetes and meet certain enrollment criteria. For more information, contact the Take Control Program at 1-800-746-2970 or e-mail takecontrolmt@gmail.com.

SOMHELP E-MAIL & BLOG

The State of Montana Healthy Employee Lifestyle Program (SOMHELP) provides a free e-mail and blog designed to provide quick health tips to keep you motivated and involved with current wellness events. For more information visit the wellness website listed above or the blog website: <http://somhelp.blogspot.com>.

EMPLOYEE ASSISTANCE PROGRAM - 2011



Contact HCBD for benefit information 1-800-287-8266 or 444-7462
www.benefits.mt.gov/wellness.mcp

Covered Services

Short-term Services
Counseling

Healthy for Life Weight Management

Health Coaching

Prenatal Program

Costs

- 4 Free, confidential counseling from any in-network provider
- Free, must meet enrollment requirements and group size is limited
- Free
- Free

GENERAL INFORMATION

WHO IS ELIGIBLE?

The Employee Assistance Program (EAP) is an add-on benefit for members of the State Employee Benefit Plan. There is no separate premium for this plan.

THE BENEFITS

The EAP benefits provide a variety of services including mental health, weight management, prenatal services, and health coaching.

PRENATAL PROGRAM

Health plan members have access to free prenatal services including;

- risk assessments,
- educational information,
- referrals, and
- other resources to help achieve a healthier pregnancy.
- Free prenatal vitamins available through URx.
- **As an enhanced benefit, Managed Care plan members who enroll in this prenatal program in their first trimester will have many deductibles and copayments waived (see pages 12 & 13).**

You can enroll in this program by simply calling 1-800-287-8266.

HEALTHY FOR LIFE WEIGHT MANAGEMENT

Starting January 1, 2011, a new weight management pilot program called the Healthy for Life Program is beginning. This is a 16-week module that will include one on one sessions with a dietitian and nurse case manager, structured group webinars, and motivational incentives. If you are interested in participating, please visit www.benefits.mt.gov/wellness.mcp or contact the Health Care and Benefits Division.

HEALTH COACHING

Have you been thinking about losing weight or quitting smoking for good? A health coach can provide the support you need to achieve your goals.

All State plan members/dependents 18 or over have access to free, confidential health coaching. This benefit, designed in conjunction with the Wellness Program, offers individuals the opportunity to communicate with friendly, experienced health coaches at their own pace, by phone or email depending on the participant's preference. To get started, contact Health Care and Benefits Division.

FREE COUNSELING SERVICES

Members of the State Employee Benefit plan are provided up to four counseling services at a participating or in-network provider free of charge. Claims will be processed through your health plan and the benefit visit maximum does apply. Regular benefits will apply after your fourth visit (see page 12-13).

Four Free counseling services must be provided by a participating (Traditional) or in-network (Managed Care) provider.

LEGAL AND FINANCIAL SERVICES

Check the Health Care and Benefits Division website at www.benefits.mt.gov for information on legal and financial services available in your community.

You must enroll during your first trimester to qualify for the enhanced benefit in the prenatal program.

PRE-TAX PLAN - 2011

Administered by the State of Montana Health Care and Benefits Division
1-800-287-8266 or 444-7462 in Helena • www.benefits.mt.gov



Benefit of Participation

Pre-tax Eligible

Eligible Premiums

- Medical, dental, vision, accidental death & dismemberment coverage, up to \$50,000 in employee term life, long term disability and flexible spending account elections.

*IRS regulations do not permit refunds of premiums paid pre-tax. Be sure to notify the Health Care and Benefits Division of any changes as soon as possible to avoid losing premiums.

GENERAL INFORMATION

The State offers benefits to employees who are eligible through a cafeteria plan as authorized by Section 125 of the Internal Revenue Code.

The Pre-tax Plan allows you to pay for your portion of most of your insurance premiums on a pre-tax basis and save money on your taxes. If the state contribution covers your insurance elections entirely, you do not pay premiums out-of-pocket. If so, you do not need to participate in the Pre-tax Plan, unless you have a Flexible Spending Account. Benefit Plan members enrolled in a Flexible Spending Account must participate in the Pre-tax Plan.

Your current pre-tax election will continue into the next benefit year, unless you indicate otherwise.

WHO IS ELIGIBLE?

All employees enrolled in the State Employee Benefit Plan are eligible to participate in the Pre-tax Plan.

Your current election will continue unless you change your election. Employees who enroll in a Flexible Spending Account are required to participate in the Pre-tax Plan.

ELIGIBLE BENEFITS

Premiums for the member's medical, dental, vision, accidental death & dismemberment (AD&D), employee term life, long term disability, and flexible spending elections may be paid pre-tax through the Pre-tax Plan. Additionally, premiums for the member's tax qualified dependents are also eligible for this plan.

INELIGIBLE BENEFITS

Dependent life insurance coverage, supplemental spouse life insurance coverage, and long term care insurance coverage are defined by IRS code as taxable benefits and are excluded from the Pre-tax Plan. Member's non-qualified tax dependents do not qualify for the Pre-tax Plan.

RETIREES & COBRA MEMBERS

Retirees and COBRA members may prepay premiums through the end of the year in which their employee coverage terminates. These premiums may be taken on a pre-tax basis if you are currently enrolled in the pre-tax plan. However, if you are thinking about leaving State employment and either taking COBRA or retiring, consider your circumstances carefully before prepaying premiums. If you have mid-year coverage changes that reduce the amount of your premium, *no refund of premiums is available.*

If you are on COBRA and you or your spouse lose eligibility because you obtain other employment offering coverage or become eligible for Medicare, *no refund of prepaid premiums is available.*

If you are a retiree and no longer need state insurance because of other coverage, *no refund of prepaid premiums is available.*

Consult your tax advisor to determine the specific effect the Pre-tax Plan will have on your taxes.

WHAT'S THE CATCH?

According to an interpretation of IRS rules, a potential drawback of the Pre-tax Plan is that no refund of overpaid premiums is available. This means you must notify the Health Care and Benefits Division right away if a dependent spouse or child loses eligibility for coverage. If you do not notify the Division of a loss of eligibility, and more premiums are taken out of your check than you owe, no refund of premiums is available. Also, remember that gross earnings for purposes of determining social security benefits are reduced by pre-tax deductions.

LOSS OF ELIGIBILITY

If the employee divorces, their former spouse and any stepchildren will lose their eligibility.

Dependent children will lose their eligibility if/when the dependent child turns 26 years old or joins the military. Dependents losing eligibility for coverage due to divorce, turning age 26 or joining the military will become ineligible at the end of the month for which a partial or full premium has been paid.

FLEXIBLE SPENDING ACCOUNTS - 2011

Administered by Allegiance Benefit Plan Management • 1-866-339-4310 • FAX 1-877-424-3539
www.allegianceflexadvantage.com



Account Types

Health FSA

Annual Amounts

- Minimum: \$120
- Maximum: \$5,000/Employee

Qualifying Expense Examples

- Eye exams, contact lenses and solution, glasses, LASIK surgery, dental exams and services, chiropractic care, prescription drugs and insulin, hearing aids and exams, doctor visits, copays, and deductibles.
- Day care centers (must comply with state and local laws), baby-sitters, preschool, and general-purpose day camps.

Dependent Care FSA

- Minimum: \$120
- Maximum: \$5,000/Family

Administrative Fee

\$2.26 per month for one or both types of FSAs.

GENERAL INFORMATION

WHO IS ELIGIBLE?

All active employees eligible for State benefits are eligible for the Flexible Spending Account (FSA) Program. Retirees, Legislators, and COBRA members are not eligible to participate.

HOW FSAs WORK

When you participate in an FSA, you elect to have a specified amount of “before tax” dollars deducted from your paycheck each pay period. There are two areas in which you can elect to use this “before tax” money for your expenses:

1. Out-of-pocket medical expenses (not covered by insurance)
 - a. health insurance deductibles, copays and coinsurance
 - b. prescription drug costs
 - c. dental and vision expenses
 - d. non-covered medical expenses
2. Dependent care expenses
 - a. child care (age 12 and under)
 - b. disabled dependent care

The Health and Dependent Care FSAs are separate accounts. If you enroll in both, you may not use funds deposited in the Health FSA for dependent care expenses, or vice-versa.

Use It or Lose It!

Be careful when deciding on your election amount to make sure you do not elect more than you know that you and your tax dependents are going to use within the plan year. Under the “use-or-lose” rule, any money not used by the end of the plan year cannot be returned to you. No changes are allowed to your election after the **October 27, 2010** deadline unless you experience a “qualifying event” described on the next page.

IMPORTANT!

You **MUST RE-ENROLL** each year to participate in a Flexible Spending Account. Enrollment is not automatic!

Getting Reimbursed

Reimbursement request forms with accompanying documentation, can be mailed, faxed or sent by secure email.

Mail to:
Allegiance Benefit Plan Management, Inc,
PO BOX 4346
Missoula, MT 59806-4346
Fax to:
1-877-424-3539 (toll-free) or 1-406-523-3149

Send scanned claims securely through the website:
www.allegianceflexadvantage.com

If you have a Health Flexible Spending Account, (FSA), complete a reimbursement request form for out-of-pocket medical expense reimbursement. If the services provided were covered by insurance, include the explanation of benefits (EOB) from your insurance carrier. A bill from the provider that estimates insurance payments is not adequate documentation. If the services were not covered by insurance, include the bill or receipt. Remember, it doesn't matter when (or if) you paid for the services, it only matters that services were actually received during the plan year.

If you have a Dependent Care FSA, complete a reimbursement request form to file a claim. Your provider can sign the form, or you can include a billing statement or receipt from your daycare provider showing expenses and service dates. If the amount you pay for dependent care is the same every month, call Allegiance about the new Day Care Contract, or find the contract on the website at www.allegianceflexadvantage.com

FSAs PUT TAX DOLLARS BACK IN YOUR POCKET

Mary is a single mother of two earning a salary of \$3,000 per month. Her oldest child has braces and Mary is paying the orthodontist \$150 per month. Mary takes a prescribed maintenance drug that costs her \$50 per month. Mary's youngest child attends preschool while Mary is at work and she is paying \$300 per month to the daycare provider. The following is a comparison of Mary's monthly take-home pay if she enrolls in FSAs to her take-home pay without FSA enrollment.

	FSA	No FSA
Gross pay	\$3000	\$3000
FSA election	<u>\$ 500</u>	<u>\$ 0</u>
Taxable Pay	\$2500	\$3000
Fed Tax*	\$ 145	\$ 225
State Tax*	\$ 85	\$ 125
FICA	<u>\$ 190</u>	<u>\$ 230</u>
Net Pay	\$2080	\$2420
Prescription	\$ 0	\$ 50
Braces	\$ 0	\$ 150
Day care	<u>\$ 0</u>	<u>\$ 300</u>
Net Pay	\$2080	\$1920

*tax based on 2010 Federal and Montana payroll tax withholding tables, claiming 3 allowances.

Participation in FSAs allows Mary to put an extra \$160.00 in her pocket each month, and \$1,920.00 additional yearly income.

TAX ISSUES

Health care expenses reimbursed through the flex plan are exempt from all federal and state income and FICA/Medicare taxes. Since you receive pre-tax treatment on the money you place in an FSA, you cannot claim the items reimbursed to you through an FSA on your tax return. Without an FSA, medical expenses are only deductible if they exceed 7.5 percent of your adjusted gross income. Remember, gross earnings for purposes of determining Social Security benefits are reduced by pre-tax deductions.



CLICK ON IT!

Allegiance's website offers a wealth of resources for FSA participants, 24 hours-a-day, seven days a week:

- Check your account balances
- Check the status of pending claims
- View the explanation of benefits for processed claims
- Print claim and direct deposit forms
- Ask questions about your account

To get started, go to the website and establish an account and password.

www.allegianceflexadvantage.com

HEALTH FSA ACCOUNT

Before the start of each plan year, you may elect to use "before tax" dollars to pay for your out-of-pocket medical expenses, including deductibles, copays, and prescription drug costs. Dental and vision expenses may be reimbursed, too. Eligible expenses include those defined by IRS Code, Section 213(d).

The amount you elect will be reimbursed to you for the eligible expenses that you, your spouse, and your tax dependents incur during the plan year. The entire annual amount you elect can be used at any time during the plan year after your first deduction is taken. All you have to do is elect the amount you want withheld before taxes from your paycheck.

DEPENDENT CARE FSA ACCOUNT

If both you and your spouse work or you are a single parent, you may have dependent care expenses. Without a dependent care account, the only tax help for you is the Federal Child Care Tax Credit. An FSA may give you a better tax benefit, so compare them both before making your annual FSA election. A dependent receiving care must live in your home at least eight hours per day.

Your FSA lets you use "before tax" dollars to pay for the care of children age 12 and under, or individuals unable to care for themselves while you or your spouse go to work or school. The care may be provided through live-in care, baby sitters, and licensed day care centers. You cannot use "before tax" dollars to pay your spouse or one of your children under the age of 19 for providing care. Schooling expenses for kindergarten and up is not reimbursable.

The maximum that you can elect in a plan year is equal to the least of the following:

- \$5,000 married filing joint federal taxes;
- \$2,500 married filing separate federal taxes or you or your spouse's earned income.

MID-YEAR ELECTION CHANGES

There are limited opportunities to change your election during the plan year. Contributions can only be changed if you experience a family status change such as:

- marriage;
- divorce;
- birth of a baby;
- adoption of a baby;
- death of spouse/dependent child;
- a change in employment status which warrants the change.

The change must be consistent with the change in family status. For example, new dependents warrant increasing a Health FSA, not decreasing it. The change must be made within 63 days of the qualifying event or in the case of births/adoptions within 63 days after the 31-day automatic coverage ends (94 days from date of birth).

ALLEGIANCE SERVICES

Customer Service representatives are available to answer your questions by phone each business day between 7:00 a.m. and 6:00 p.m. After hours and on weekends, you can access a toll-free automated voice response system for your account information by calling 1-866-339-4310 (toll free) or 1-406-721-2222.

You can also access the Allegiance website, www.allegianceflexadvantage.com, 24 hours-a-day, seven days-a-week.

If you would like to drop off a claim reimbursement request or speak with a Customer Service Representative in person, you can stop by an Allegiance office between 8:00 a.m. and 5:00 p.m.

- Helena - 910 N. Last Chance/Suite D
- Missoula - 2806 S. Garfield
- Billings - 490 N. 31st Street, #110

HEALTH/DEPENDENT CARE FSA(S) WORKSHEETS

These worksheets will help you decide on an appropriate annual election for Health & Dependent Care FSAs. Estimate your total annual expenses for the 2011 plan year (January 1 - December 31) based on expenses to date and any additional expenses expected before December 31. For this information, refer to medical bills, financial and bank records, and this year's Explanation of Benefits statements (EOBs).

Your selected amount is removed from your paychecks in 24 installments, first from any unused state contribution, and then from gross pay (before taxes) and deposited into your FSA. As you incur eligible expenses, you turn in a simple claim form and receive payment.

HEALTH FSA WORKSHEET

<u>Common Medical Expenses</u>	2011 Estimates
Estimated Medical Expenses (deductibles, copays, coinsurance)	\$ _____
Estimated Dental Expenses	\$ _____
Estimated Vision Expenses	\$ _____
Estimated Prescription Expenses	\$ _____
Total Estimated 2011 Medical FSA	\$ _____

DEPENDENT CARE FSA WORKSHEET

<u>Monthly Care Expenses</u>	
Infant Expenses	\$ _____
Preschool Expenses	\$ _____
Before and After School Care	\$ _____
School Vacations	\$ _____
Total Monthly Expenses	\$ _____
	x 12
Total Estimated 2011 Care Expenses	\$ _____

Examples of Qualified Medical Expenses

- Alcohol & Drug Treatment
- Alternative Healers
- Ambulance
- Appliances for Hearing Impaired
- Artificial Limbs & Teeth
- Birth Control Pills
- Blood Sugar Test Kit
- Braille Books & Magazines
- Car Controls for Disabled Drivers
- Carpal Tunnel Supports
- Chelation Therapy
- Childbirth or Lamaze Classes
- Chiropractors
- Coinsurance Amounts
- Contact Lenses & Supplies
- Contraceptives
- Crutches
- Deductibles (Medical, Dental, Rx)
- Dental Care
- Dentures & Denture Adhesives
- Diagnostic Fees
- Eye exams & Prescription Lenses
- Fertility & Infertility Treatments
- First Aid Kits
- Flu Shots
- Immunizations
- Laboratory Fees
- Obstetrical Expenses
- Orthodontics
- Physician Fees
- Physical Therapy
- Prescription drugs
- Psychiatrist & Psychologist Fees
- Smoking Cessation Program
- Surgery & Surgical Fees
- Wheelchair
- X-Rays

Examples of Non-Qualified Medical Expenses

- Cosmetic Surgery
- Hair Growth Treatments
- Massage
- Service Agreements
- Teeth Whitening/Veneers
- Over the counter medications not prescribed by a medical professional
- Fitness Programs
- Insurance Premiums
- Warranties
- Special Foods
- Vitamins/Minerals

IMPORTANT!

Please be sure these amounts
divide evenly by 24
(the number of
deductions in the plan year).

LIFE INSURANCE PLANS - 2011

Administered by The Standard Insurance Company

For information, call the Health Care and Benefits Division • 1-800-287-8266 or 444-7462



Monthly Premiums

Plan A: Basic Life (\$14,000)	\$2.10	Age Rates <i>Based on employee's age the last day of month</i> <30.... \$.03 <35.... \$.05 <40.... \$.08 <45.... \$.10 <50.... \$.15 <55.... \$.23 <60.... \$.43 <65.... \$.66 65+.... \$.98
Plan B: Dependent Life	\$0.52	
Plan C: Optional Employee Life	(Age Rate) x (every \$1,000 of coverage)	
Plan D: Optional Spouse Life	(Age Rate) x (every \$1,000 of coverage)	
Plan E: Accidental Death & Dismemberment (Employee only)	\$0.020/\$1,000 of coverage	
Plan E: Accidental Death & Dismemberment (Employee plus dependents)	\$0.030/\$1,000 of coverage	

GENERAL INFORMATION

WHO IS ELIGIBLE?

The Basic Life Insurance Plan is a core benefit for all active Employees, Legislators, and non-Medicare retirees. Optional life insurance and Accidental Death & Dismemberment (AD&D) is available for employees, spouses, and dependents.

LIFE AND AD&D PLANS

Life Insurance is a type of insurance which provides a sum of money if the person who is insured dies while the policy is in effect.

Accidental Death & Dismemberment (AD&D) provides a sum of money if the insured dies or suffers a dismemberment as the result of an accident.

During Annual Change:

- You may delete coverage for plans B, C, D, and E.
- You may add or increase Plan E and apply for coverage or additional coverage under plans C and D.
- You may decrease coverage in Plan C down to your annual salary, rounded to the next highest \$5,000 increment.

CHOOSE FROM FIVE PLANS

The State of Montana offers five plans of coverage. The life insurance plans are term life, meaning they provide inexpensive protection but do not accrue any cash value.

A member is eligible to carry all life plans until termination or retirement. At termination, no life plans may be continued through COBRA. At retirement, only Plan A – Basic Life can be continued until age 65 or Medicare eligible. It's usually best to choose other life insurance if you want post-employment protection.

However, conversion/portability is available if requested at the time life coverage terminates.

Plan A – Basic Life

This plan provides \$14,000 of term-life coverage. It is a core benefit for state employees and is also available to retirees under age 65 who continue state benefits.

Plan B – Dependent Life

This plan is only available during your initial 31-day enrollment period, or within the first 63 days of acquiring a spouse or your first child. Plan B offers \$2,000 of coverage for a spouse and \$1,000 of coverage for each dependent child.

During Annual Change you can only delete existing coverage for Plan B.

Plan C – Optional Employee Life

This plan offers an insurance minimum of your annual salary rounded to the next highest \$5,000. Plan C coverage is automatically adjusted in \$5,000 increments as the employee's salary increases.

Additional amounts are available in \$5,000 increments, up to \$500,000. **These additional amounts require evidence of insurability to be submitted and approved.**

Plan D – Optional Spouse Life

This plan offers insurance on your spouse's life. During this Annual Change period, you can make a new election of Plan D coverage of \$10,000 without evidence of insurability (guaranteed enrollment). **Elections above \$10,000**

require evidence of insurability and are subject to approval. The employee must be enrolled in Plan C for their spouse to be eligible for Plan D. Coverage is available for a minimum of \$5,000.

Additional amounts are available in \$5,000 increments, up to the amount of your coverage available under Plan C.

Plan E – Optional Accidental Death & Dismemberment

This plan is available without evidence of insurability.

Employee Only: Coverage is available between a minimum of \$25,000 and a maximum of \$500,000, in increments of \$25,000. The coverage may not exceed 10 times your annual salary.

Employee and Dependents: The employee receives the same coverage as described above. A spouse with no children is eligible for 50 percent of the employee coverage. A spouse with children is eligible for 40 percent of the employee coverage. Children are eligible for 10 percent of the employee coverage.

MAKING A CHANGE

If you are adding or increasing plans C or D (above \$10,000), you will receive a Medical History Statement (application) from the Health Care and Benefits Division. You must complete and return this statement, which will be forwarded to Standard Insurance Company for underwriting and approval or denial. You will be notified of the underwriting decision and, if approved, the effective date.

LONG TERM DISABILITY INSURANCE - 2011

Administered by The Standard Insurance Company
For information, call the Health Care and Benefits Division • 1-800-287-8266 or 444-7462
www.benefits.mt.gov



Monthly Premiums

\$21.34 per member

GENERAL INFORMATION

Voluntary Long Term Disability (LTD) is insurance designed to pay a monthly benefit to you in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, thus helping you to meet your financial commitments in a time of need.

WHO IS ELIGIBLE?

Long Term Disability (LTD) coverage is a voluntary benefit available to active employees who are enrolled in the medical plan. Retirees, Legislators and COBRA members are not eligible to participate.

COST

The monthly premium per member is \$21.34 regardless of age or income level.

BENEFIT AMOUNT

The monthly LTD benefit is 60% of your insured predisability earnings, the amount you were earning before you became disabled, reduced by deductible income.

The LTD benefit amount is determined by multiplying your insured predisability earnings by the specified benefit percentage. This amount is then reduced by other income you receive or are eligible to receive while LTD benefits are payable. This other income is referred to as deductible income.

BENEFIT DURATION

If you become disabled and your claim for LTD benefits is approved by the insurance plan LTD benefits become payable after you have been continuously disabled for 180 days and remain continuously disabled. LTD benefits are not payable during this benefit waiting period.

If you become disabled before age 60, LTD benefits may continue during disability until you reach age 65.

If you become disabled at age 60 or older, the benefit duration is determined by your age when disability begins.

If you are age 60-64 when disability begins, your maximum benefit period is five years.

For ages 65-68, the maximum is to age 70.

For ages 69 and over, the maximum is one year.

MORE INFORMATION

Long Term Disability brochures are available to provide more information on the plan. Brochures are available at www.benefits.mt.gov or by calling the Health Care and Benefits Division at 1-800-287-8266 or 444-7462.

ADVANTAGES OF LTD COVERAGE

- It covers your inability to work in your own occupation for the first 24 months you are disabled, whereas many other benefits require you to be totally disabled from all occupations.

- If you are disabled from all occupations after 24 months, benefits may continue until you reach age 65.

- It covers disabilities that occur 24 hours a day, both on and off the job.

- If your employer makes an approved work-site modification that enables you to return to work while disabled, the plan will reimburse your employer up to a pre-approved amount for some or all of the cost of the modifications.

- While LTD benefits are payable, you may qualify to participate in a rehabilitation plan that prepares you to return to work. If you qualify, the plan may pay for return to work expenses you incur, such as job search, training and education, and family care expenses.

- If you die while LTD benefits are payable, and on the date you die you have been continuously disabled for at least 180 days, a survivors benefit equal to three times your un-reduced LTD benefit may be payable.

- If the group policy terminates, LTD benefits will continue as long as you are eligible to receive them.

LONG TERM CARE INSURANCE - 2011

Provided by UNUM Life Insurance Company
1-800-227-4165 • www.unum.com



Options	Choices
Care Type	
Plan 1	• Facility (<i>nursing home or assisted living</i>)
Plan 2	• Facility + Professional Home Care (<i>Provided by a licensed home health organization</i>)
Plan 3	• Facility + Professional Home Care + Total Home Care (<i>Care provided by anyone, including family members</i>)
Monthly Benefit	
Nursing Home	• \$1,000 - \$6,000
Assisted Living	• 60% of the selected nursing home amount
Home Care	• 50% of the selected nursing home amount
Duration	
3 year	• 3 years Nursing Home
6 year	• 6 years Nursing Home
Unlimited	• Unlimited Nursing Home
	• or 5 years Assisted Living
	• or 10 years Assisted Living
	• or Unlimited Assisted Living
	• or 6 years Home Care
	• or 12 years Home Care
	• or Unlimited Home Care
Inflation Protection	
Yes	• 5% compounded annually
No	• No protection

GENERAL INFORMATION

WHO IS ELIGIBLE?

Employees, Legislators, Retirees, Spouses, Parents, and Parents-in-Law are eligible for the Long-Term Care Insurance Plan. This plan may be elected, changed or dropped at anytime.

ENROLLMENT

If you would like to sign-up for the plan, you may request an enrollment kit by calling the Health Care and Benefits Division at 1-800-287-8266 (444-7462 in Helena) or via e-mail at benefitsquestions@mt.gov.

LONG TERM CARE OPTIONS

The Long-Term Care Insurance Plan offers a variety of options, all of which affect the monthly premium. These options are:

- Care types
- Monthly benefit amounts
- Care durations
- Inflation protections

Types of Care

Plan 1: Facility (Nursing Home or Assisted Living)

Plan 2: Facility plus Professional Home Care (provided by a licensed home health organization)

Plan 3: Facility plus Professional Home Care plus Total Home Care (provided by anyone, including family members)

Monthly Benefit Amounts

- Nursing home monthly benefit amounts of \$1,000, \$2,000, \$3,000, \$4,000, \$5,000 or \$6,000 are available.

- Assisted living facility monthly benefit amounts total 60 percent of the selected nursing home amount.

- Home care monthly benefit amounts total 50 percent of the selected nursing home amount.

Duration

Three Year: Provides 3 years nursing home care, 5 years assisted living facility care, or 6 years home care.

Six Years: Provides 6 years nursing home care, 10 years assisted living facility care, or 12 years home care.

Unlimited: Provides an unlimited amount of care at a nursing home, assisted living facility, or a home.

Inflation Protection

Yes: An inflation protection of 5 percent will be compounded annually.

No: No inflation protection will be provided.

LONG-TERM CARE INSURANCE RATES

For rates
with
Inflation
Protection,
see page 33

Rates shown are for a \$1,000 Monthly Facility Benefit.
You may choose from \$1,000 - \$6,000 in Facility Monthly Benefits.

PLAN 1

Long-Term Care Facility
Non-forfeiture

PLAN 2

Long-Term Care Facility
Non-forfeiture
Professional Home Care

PLAN 3

Long-Term Care Facility
Non-forfeiture
Total Home Care

Benefit Duration	3 YR	6 YR	Unlimited	3 YR	6 YR	Unlimited	3 YR	6 YR	Unlimited
Age 18 - 30	1.70	2.10	2.80	2.60	3.40	4.70	4.00	5.30	7.60
31	1.70	2.20	2.80	2.60	3.50	4.70	4.00	5.50	7.70
32	1.70	2.20	2.90	2.60	3.60	4.90	4.10	5.60	7.90
33	1.80	2.30	2.90	2.70	3.70	5.00	4.20	5.70	8.00
34	1.80	2.30	3.00	2.80	3.70	5.10	4.30	5.80	8.20
35	1.90	2.40	3.10	2.90	3.90	5.20	4.40	6.00	8.50
36	1.90	2.60	3.20	2.90	4.00	5.40	4.50	6.20	8.70
37	2.00	2.70	3.30	3.10	4.20	5.60	4.70	6.40	9.00
38	2.10	2.80	3.40	3.20	4.30	5.80	4.90	6.70	9.30
39	2.20	2.90	3.60	3.40	4.50	6.00	5.10	6.80	9.60
40	2.30	3.00	3.80	3.50	4.60	6.20	5.20	7.10	10.00
41	2.40	3.10	4.00	3.60	4.80	6.60	5.50	7.40	10.40
42	2.50	3.30	4.00	3.80	5.00	6.70	5.70	7.70	10.70
43	2.60	3.40	4.30	3.90	5.30	7.10	5.90	8.00	11.20
44	2.70	3.60	4.50	4.10	5.50	7.40	6.20	8.40	11.80
45	2.90	3.80	4.70	4.30	5.80	7.70	6.50	8.80	12.30
46	3.00	4.00	5.00	4.50	6.10	8.10	6.80	9.30	12.90
47	3.30	4.20	5.30	4.70	6.30	8.50	7.10	9.80	13.60
48	3.40	4.50	5.60	4.90	6.70	8.80	7.50	10.30	14.30
49	3.70	4.70	5.90	5.20	6.90	9.20	7.90	10.80	15.10
50	3.90	5.10	6.30	5.40	7.30	9.70	8.30	11.40	16.00
51	4.20	5.40	6.80	5.80	7.60	10.20	8.90	12.10	16.90
52	4.50	5.80	7.20	6.10	8.10	10.80	9.50	12.90	18.00
53	4.80	6.20	7.70	6.50	8.50	11.30	10.00	13.50	19.00
54	5.10	6.60	8.20	6.80	9.00	11.90	10.50	14.30	20.10
55	5.50	7.10	8.70	7.30	9.60	12.50	11.20	15.30	21.20
56	6.00	7.70	9.50	7.70	10.20	13.40	11.90	16.30	22.80
57	6.50	8.40	10.30	8.30	10.90	14.20	12.80	17.50	24.40
58	7.10	9.10	11.20	8.90	11.70	15.20	13.60	18.70	26.10
59	7.80	9.90	12.20	9.50	12.60	16.30	14.70	20.00	28.00
60	8.50	10.80	13.30	10.30	13.40	17.40	15.70	21.40	30.00
61	9.40	12.00	14.70	11.20	14.70	19.00	17.00	23.40	32.60
62	10.50	13.30	16.20	12.30	16.00	20.50	18.40	25.20	35.20
63	11.60	14.70	18.00	13.40	17.50	22.50	19.90	27.40	38.40
64	12.90	16.40	19.90	14.80	19.20	24.50	21.70	29.90	41.70
65	15.00	18.90	22.90	16.80	21.80	27.70	24.20	33.40	46.60
66	16.60	20.90	25.40	18.50	24.00	30.40	26.10	36.10	50.50
67	18.60	23.40	28.30	20.60	26.60	33.60	28.60	39.50	55.10
68	20.70	25.90	31.40	22.80	29.40	37.20	31.20	43.10	60.10
69	23.00	28.80	34.90	25.20	32.40	41.00	34.10	47.00	65.60
70	25.70	32.00	38.70	28.00	35.90	45.30	37.20	51.40	71.50
71	28.40	35.40	42.80	30.80	39.50	49.80	40.40	55.90	77.70
72	31.60	39.40	47.50	34.20	43.80	55.00	44.20	61.20	84.90
73	34.90	43.30	52.10	37.60	47.90	60.00	48.10	66.50	91.80
74	38.80	48.00	57.60	41.50	53.00	66.10	52.60	72.70	100.00
75	46.50	57.40	68.60	49.60	63.10	78.70	62.20	86.00	118.00
76	51.20	63.30	75.90	54.50	69.40	86.40	67.60	93.60	128.40
77	55.90	69.00	82.70	59.30	75.40	93.80	72.80	100.90	138.30
78	61.50	75.80	90.70	65.00	82.60	102.60	79.20	109.80	150.20
79	67.70	83.40	99.60	71.40	90.60	112.30	86.20	119.50	163.10
80	74.60	91.60	109.30	78.40	99.30	122.90	93.80	130.00	177.10
81	81.70	100.10	119.20	85.60	108.20	133.60	101.40	140.50	190.80
82	90.80	111.10	132.00	95.00	119.80	147.50	111.70	154.60	209.20
83	100.50	122.60	145.50	104.90	132.10	162.20	122.70	169.70	228.90
84	109.90	133.80	158.30	114.60	143.90	176.10	133.20	184.20	247.10

LONG-TERM CARE INSURANCE RATES

Rates shown are for a \$1,000 Monthly Facility Benefit with Inflation Protection.
You may choose from \$1,000 - \$6,000 in Facility Monthly Benefits.

**With
Inflation
Protection**

PLAN 1

**Long-Term Care Facility
Non-forfeiture**

PLAN 2

**Long-Term Care Facility
Non-forfeiture
Professional Home Care**

PLAN 3

**Long-Term Care Facility
Non-forfeiture
Total Home Care**

Benefit Duration		3 YR	6 YR	Unlimited		3 YR	6 YR	Unlimited		3 YR	6 YR	Unlimited
Age	18-30	6.00	7.80	10.00		8.20	10.90	14.60		11.50	15.40	21.50
	31	6.10	8.10	10.20		8.30	11.20	14.90		11.70	15.90	22.00
	32	6.20	8.20	10.60		8.50	11.40	15.40		12.00	16.20	22.50
	33	6.50	8.60	10.80		8.70	11.80	15.70		12.20	16.60	23.00
	34	6.60	8.70	11.00		9.00	12.00	16.00		12.50	17.00	23.40
	35	6.90	9.00	11.40		9.30	12.40	16.40		12.90	17.50	24.10
	36	7.00	9.20	11.70		9.50	12.70	16.90		13.20	17.90	24.60
	37	7.20	9.60	12.00		9.70	13.10	17.40		13.50	18.40	25.30
	38	7.50	9.90	12.40		10.10	13.50	17.80		14.00	19.00	26.00
	39	7.70	10.00	12.70		10.40	13.70	18.20		14.30	19.30	26.50
	40	7.90	10.40	13.00		10.60	14.10	18.70		14.60	19.80	27.30
	41	8.20	10.60	13.50		10.90	14.50	19.30		15.10	20.30	28.00
	42	8.40	10.90	13.70		11.20	14.90	19.60		15.40	20.80	28.60
	43	8.60	11.30	14.10		11.50	15.30	20.20		15.90	21.40	29.40
	44	9.00	11.70	14.60		11.90	15.90	20.80		16.40	22.10	30.30
	45	9.20	11.90	14.90		12.30	16.20	21.30		16.80	22.60	31.00
	46	9.60	12.50	15.50		12.60	16.80	22.00		17.30	23.40	32.10
	47	9.90	12.80	16.10		12.90	17.10	22.50		17.90	24.10	33.10
	48	10.20	13.20	16.60		13.20	17.50	23.10		18.40	24.90	34.20
	49	10.70	13.80	17.10		13.70	18.10	23.60		19.10	25.70	35.20
	50	11.00	14.20	17.80		14.00	18.50	24.30		19.60	26.50	36.50
	51	11.50	14.80	18.50		14.60	19.20	25.10		20.50	27.60	38.00
	52	12.10	15.50	19.30		15.10	19.90	25.90		21.30	28.70	39.40
	53	12.40	16.00	19.90		15.40	20.30	26.60		21.90	29.60	40.80
	54	12.90	16.70	20.80		15.90	21.10	27.40		22.60	30.70	42.20
	55	13.80	17.70	21.90		16.70	21.90	28.30		23.50	31.70	43.30
	56	14.50	18.60	23.00		17.40	22.80	29.40		24.50	33.10	45.20
	57	15.30	19.60	24.20		18.30	23.80	30.80		25.80	34.70	47.60
	58	16.20	20.80	25.60		19.10	25.00	32.10		26.90	36.40	49.90
	59	17.10	21.90	26.90		20.00	26.10	33.60		28.20	38.10	52.30
	60	18.30	23.10	28.40		21.10	27.30	35.00		29.60	40.00	54.80
	61	19.70	25.20	30.80		22.50	29.40	37.50		31.50	42.80	58.70
	62	21.40	27.10	33.00		24.20	31.30	39.70		33.50	45.50	62.30
	63	22.90	29.10	35.50		25.70	33.30	42.30		35.50	48.30	66.30
	64	25.00	31.60	38.40		27.80	35.90	45.20		38.00	51.70	70.80
	65	28.10	35.50	43.00		30.90	39.80	50.00		41.70	56.80	77.80
	66	30.40	38.30	46.40		33.10	42.70	53.70		44.20	60.30	82.80
	67	33.20	41.80	50.50		36.10	46.40	58.20		47.60	65.10	89.10
	68	35.90	45.20	54.60		38.90	50.00	62.70		50.80	69.40	95.10
	69	39.20	48.90	59.20		42.30	54.00	67.80		54.60	74.40	102.20
	70	42.30	52.90	64.00		45.50	58.20	73.10		58.20	79.60	109.30
	71	46.10	57.50	69.30		49.40	63.10	78.90		62.40	85.50	117.10
	72	50.20	62.70	75.50		53.70	68.50	85.60		67.20	92.10	125.90
	73	54.10	67.10	80.80		57.70	73.40	91.40		71.80	98.20	134.00
	74	59.00	73.00	87.60		62.60	79.60	98.80		77.20	105.60	143.70
	75	69.20	85.60	102.50		73.30	93.00	115.30		89.70	122.70	166.50
	76	75.30	93.00	111.50		79.50	100.80	125.00		96.40	132.10	179.20
	77	80.60	99.40	119.10		84.80	107.50	133.30		102.00	139.90	189.70
	78	87.40	107.70	128.80		91.80	116.10	143.70		109.50	150.10	203.20
	79	94.10	115.80	138.50		98.70	124.80	154.20		117.00	160.70	217.20
	80	102.20	125.60	149.80		106.90	135.00	166.50		125.80	172.70	233.10
	81	110.20	135.10	161.00		115.10	145.00	178.50		134.40	184.40	248.40
	82	120.80	147.70	175.60		125.80	158.20	194.40		146.00	200.30	269.00
	83	131.70	160.70	190.70		137.00	172.00	210.70		158.40	217.20	290.70
	84	141.70	172.70	204.20		147.30	184.60	225.30		169.40	232.60	309.90

URx NETWORK PHARMACIES

CITY	PHARMACY
Anaconda	Community Hosp Anaconda Phcy CVS Pharmacy Safeway Pharmacy Thrifty Drug Store
Ashland	Riverstone Pharmacy
Baker	Baker Rexall Drug
Belgrade	Lee & Dad's Pharmacy Osco Pharmacy
Big Sky	Bozeman Deaconess Pharmacy
Big Timber	Pamida Pharmacy
Bigfork	Bigfork Drug
Billings	Billings Clinic Pharmacy Billings Health & Rehab Community Billings VA CBOC Pharmacy Center for Healthy Aging Phcy Costco Pharmacy CVS Pharmacy-Central CVS Pharmacy - Grand Ave. CVS Pharmacy - Main St. CVS Pharmacy - North 27th St. Deaconess Billings Clinic- Ave C Deaconess Billings Clinic- 10th Ave N First Pharmacy Juro's United Drugs K Mart Pharmacy Omnicare of Billings Osco Pharmacy - Central Ave. Osco Pharmacy - Grand Ave. Osco Pharmacy - North 27th St. Osco Pharmacy - Main St. Planned Parenthood of Montana Pharmacy One Riverstonehealth Pharmacy SAMS Pharmacy ST Johns Pharmacy Shopko Pharmacy Target Pharmacy Walgreens Drug Store - Main St. Walgreens Drug Store - Grand Ave. Wal-Mart Pharmacy - Main St. Wal-Mart Pharmacy - King Ave. Woodrows Drugs
Boulder	Elkhorn Pharmacy Inc
Box Elder	Rocky Boy Health Board
Bozeman	Costco Pharmacy CVS Pharmacy Highland Park Pharmacy K Mart Pharmacy Medical Arts Pharmacy MSU Student Health Service Pharm Osco Pharmacy Price Rite Drug Rosauers Pharmacy Safeway Pharmacy Smith's Pharmacy

*Network Pharmacies are subject to change



CITY	PHARMACY
	Wal-Mart Pharmacy Western Drug
Broadus	Broadus IGA Pharmacy
Browning	Blackfeet Community Health Hospital
Butte	Community Health Center Pharmacy CVS Pharmacy Driscoll Drug K Mart Pharmacy Medical Arts Pharmacy Safeway Pharmacy Three Bears Pharmacy Wal-Mart Pharmacy
Chester	Liberty Drug Westhill Pharmacy
Chinook	Chinook Pharmacy
Choteau	Choteau Drug
Columbia Falls	Columbia Falls VA CBOC Pharmacy Good Medicine Pharmacy Montana Veterans Home Pamida Pharmacy Smith's Pharmacy
Columbus	Columbus Health Mart
Conrad	Olson's Drug Village Drug
Corvallis	Corvallis Drug Store
Crow Agency	Crow Indian Hospital Pharmacy
Culbertson	Culbertson Pharmacy
Cut Bank	Drug Mart Osco Pharmacy
Deer Lodge	Keystone Drug Safeway Pharmacy
Dillon	Pamida Pharmacy Safeway Pharmacy

URx NETWORK PHARMACIES

CITY	PHARMACY	CITY	PHARMACY
Ennis	Ennis Health Mart Pharmacy	Hays	Hays Health Center Pharmacy
Eureka	Eureka Drug Pamida Pharmacy	Heart Butte	Heart Butte Pharmacy
Fairfield	Fairfield Drug	Helena	Bergum Drug South Hills Costco Pharmacy CVS Pharmacy - N. Montana Ave. CVS Pharmacy - Euclid Ave. Osco Pharmacy K Mart Pharmacy Safeway Pharmacy Shopko Pharmacy South Hills Pharmacy Inc St. Peter's Pharmacy Walgreens Wal-Mart Pharmacy
Fairview	Mondak Pharmacy	Kalispell	Big Sky IV Care Costco Pharmacy Evergreen Rx Glacier Ridge Pharmacy Kalispell Regional Med. Ctr Pharmacy K Mart Pharmacy Medical Arts Pharmacy Osco Pharmacy Rosauers Pharmacy Shopko Pharmacy Smith's Pharmacy Sykes Pharmacy The Clinical Pharmacy Wal-Mart Pharmacy Walgreens Drug Store
Florence	Florence Pharmacy North	Lame Deer	Lame Deer Health Center Pharmacy
Forsyth	Yellowstone Pharmacy	Laurel	CVS Pharmacy Gene's Pharmacy Price's Pharmacy Wal-Mart Pharmacy
Fort Benton	Benton Pharmacy	Lewistown	Lewistown Pharmacy Osco Pharmacy Pamida Pharmacy Seiden Drug
Frenchtown	Frenchtown Drug	Libby	Center Drug Frank's Drug Libby Drug Rosauers Pharmacy
FT Harrison	Fort Harrison VAMC Pharmacy	Livingston	KC Western Drug Long Tern Care Osco Pharmacy Pamida Pharmacy Western Drug
Gardiner	Gardiner Pharmacy	Lodge Grass	Lodge Grass Health Center Pharmacy
Glasgow	Fifthe Ave Pharmacy & Gift Pamida Pharmacy Western Drug of Glasgow	Lolo	Lolo Drug
Glendive	F & G Pharmacy Gabert Clinic Pharmacy Osco Pharmacy	Malmstrom AFB	Malmstrom Pharmacy
Great Falls	Anderson Family Pharmacy Apothecary Drug Store Clinic Pharmacy CVS Pharmacy K Mart Pharmacy Osco Pharmacy - 3rd St. NW Osco Pharmacy - 10th Ave. S Pharmerica Plaza United Pharmacy Public Drug Sam's Club Pharmacy Shopko Pharmacy Smith's Pharmacy Snyder Drugs Spectrum Pharmacy Walgreens Drug Store - 3rd St. NW Walgreens Drug Store - 10th Ave. S Wal-Mart Pharmacy	Malta	Valley Drug
Hamilton	Bitterroot Drug Hamilton Pharmacy Health Care Plus Osco Pharmacy Timber Ridge Pharmacy Walgreens	Miles City	Big Sky Pharmacy
Hardin	Pharmcare Pharmacy		
Harlem	Fort Belknap Health Center Pharmacy Milk River Pharmacy		
Harlowtown	Wheatland Memorial Pharmacy		
Havre	Health Mart K Mart Pharmacy Northern Montana Pharmacy Wal-Mart Pharmacy Western Drug Pharmacy		

URx NETWORK PHARMACIES

CITY	PHARMACY	CITY	PHARMACY
	Miles City CBOC Osco Pharmacy Wal-Mart Pharmacy	Sidney	Clinic Pharmacy Pamida Pharmacy White Drug
Missoula	A & C Drug Broadway Pharmacy CMC Retail Rx Costco Pharmacy CVS Pharmacy East Gate Drug Health Service Pharmacy Uni of MT Hillside Health Care Center K Mart Pharmacy Missoula Pharmacy Osco Pharmacy - Oxford St. Osco Pharmacy - Reserve St. Osco Pharmacy - Russell St. Palmer's Drug Partnership Health Center Pharmacy Rosauers Pharmacy Safeway Pharmacy - Reserve St. Safeway Pharmacy - Broadway St. Savmor Drug Shopko Pharmacy Target Pharmacy Village Health Care Center Wal-Mart Pharmacy - Mullan Rd. Wal-Mart Pharmacy - Hwy 93 Walgreens Drug Store - N. Reserve St. Walgreens Drug Store - Brooks St.	St. Ignatius	CS and K Tribes-Flathead Reservation Mission Drug Pharmacy
		Stevensville	Ridgeway Pharmacy Family Pharmacy Valley Drug
		Superior	Mineral Pharmacy
		Thompson Falls	Doug's Drug
		Three Forks	Railway Drug
		Townsend	Townsend Drug
		Troy	Kootenai Drug
		Victor	North Ridge Health Care Ridgeway Pharmacy Ltd
		Warm Springs	Montana State Hospital Pharmacy
		West Yellowstone	Silvertip Pharmacy
		White Sulphur Springs	Castle Mountain Drug
		Whitefish	Alpine Ridge Pharmacy Haines Medical Pharmacy Safeway Pharmacy Walgreens Whitefish Discount Pharmacy
Philipsburg	Granite Co Medical Hospital Pharmacy	Whitehall	Whitehall Drug
Plains	Plains Drug	Wolf Point	Wolf Point Health Center Pharmacy Wolf Point IDE Pharmacy
Plentywood	Plentywood Drug		
Polson	Healthcare Plus Pharmacy- Hwy 93 Healthcare Plus Pharmacy- 7th Ave E Safeway Pharmacy St. Joseph's Retail Pharmacy Wal-Mart Pharmacy		
Poplar	Poplar Health Center Pharmacy Poplar Pharmacy		
Pryor	Pryor Health Station Pharmacy		
Red Lodge	Red Lodge Drug		
Ronan	Family Health Pharmacy R & R Health Care Solutions		
Roundup	Pamida Pharmacy		
Scoby	Service Drug Inc		
Seeley Lake	Seeley Swan Pharmacy		
Shelby	Northtown Drug Pamida Pharmacy		
Sheridan	Mac's CHC Pharmacy		

BLUE CHOICE MANAGED CARE AREAS

City	Zip Code	City	Zip Code	City	Zip Code	City	Zip Code
Absarokee	59001	Dixon	59831	Kila	59920	Roscoe	59071
Acton	59002	Drummond	59832	Kremlin	59532	Roundup	59072
Alberton	59820	Dupuyer	59432	Lake McDonald	59921	Rudyard	59540
Alder	59710	Dutton	59433	Lakeside	59922	Ryegate	59074
Anaconda	59711	East Helena	59635	Laurel	59044	Saltese	59867
Arlee	59821	East Missoula	59801	Lavina	59046	Sand Coulee	59472
Augusta	59410	Edgar	59026	Ledger	59456	Santa Rita	59473
Avon	59713	Elliston	59728	Lima	59739	Seeley Lake	59868
Ballantine	59006	Elmo	59915	Lincoln	59639	Shawmut	59078
Basin	59631	Emigrant	59027	Livingston	59047	Shelby	59474
Bearcreek	59007	Ennis	59729	Lloyd	59535	Shepherd	59079
Belfry	59008	Ethridge	59435	Lodge Grass	59050	Sheridan	59749
Belgrade	59714	Eureka	59917	Lolo	59847	Silver Star	59751
Belt	59412	Fairfield	59436	Loma	59460	Silverbow	59750
Big Arm	59910	Fishtail	59028	Lonepine	59848	Simms	59477
Bigfork	59911	Florence	59833	Lothair	59461	Somers	59932
Big Sky	59716	Floweree	59440	Malmstrom AFB	59402	Springdale	59082
Billings	59101-59104	Fort Benton	59442	Manhattan	59741	St. Ignatius	59865
	59106-59108	Fort Harrison	59636	Marion	59925	St. Regis	59866
	59111-59112	Fort Shaw	59443	Martin City	59926	St. Xavier	59075
	59114-59117	Fortine	59918	Martinsdale	59053	Stevensville	59870
Black Eagle	59414	Frenchtown	59834	Marysville	59640	Stockett	59480
Bonner	59823	Fromberg	59029	McAllister	59740	Stryker	59933
Boulder	59632	Galata	59444	McLeod	59052	Sula	59871
Box Elder	59521	Gallatin Gateway	59730	Melrose	59743	Sun River	59483
Boyd	59013	Garneill	59445	Melville	59055	Sunburst	59482
Bozeman	59715	Garrison	59731	Milltown	59851	Superior	59872
	59717-59719	Garryowen	59031	Missoula	59801-59804	Swan Lake	59911
	59771-59773	Geraldine	59446		59806-59808	Thompson Falls	59873
Brady	59416	Geyser	59447		59812	Three Forks	59752
Bridger	59014	Gildford	59525	Molt	59057	Townsend	59644
Broadview	59015	Glen	59732	Monarch	59463	Trego	59934
Buffalo	59418	Gold Creek	59733	Montana City	59634	Trout Creek	59874
Butte	59701-59703	Grantsdale	59835	Musselshell	59059	Twin Bridges	59754
	59707	Great Falls	59401	Neihart	59465	Two Dot	59085
			59403-59406	Norris	59745	Ulm	59485
Bynum	59419	Greenough	59836	Noxon	59853	Valier	59486
Canyon Creek	59633	Hamilton	59840	Oilmont	59466	Vaughn	59487
Cardwell	59721	Hardin	59034	Olney	59927	Victor	59875
Carter	59420	Harlowton	59036	Ovando	59854	Virginia City	59755
Cascade	59421	Harrison	59735	Pablo	59855	Warm Springs	59756
Charlo	59824	Haugan	59842	Paradise	59856	West Glacier	59936
Chester	59522	Havre	59501	Park City	59063	White Slphr Sprgs	59645
Chinook	59523	Helena	59601-59602	Pendroy	59467	Whitefish	59937
Choteau	59422		59604	Philipsburg	59858	Whitehall	59759
Clancy	59634		59620	Pinesdale	59841	Whitlash	59545
Clinton	59825		59623-59626	Plains	59859	Wilsall	59086
Clyde Park	59018	Helmville	59843	Polaris	59746	Winston	59647
Columbia Falls	59912	Heron	59844	Pole Bridge	59928	Wisdom	59761
Condon	59826	Highwood	59450	Polson	59860	Wise River	59762
Conner	59827	Hingham	59528	Pompeys Pillar	59064	Wolf Creek	59648
Conrad	59425	Hot Springs	59845	Pony	59747	Worden	59088
Coram	59913	Hungry Horse	59919	Power	59468	Zurich	59547
Corvallis	59828	Huntley	59037	Pray	59065		
Creston	59902	Huson	59846	Proctor	59929		
Crow Agency	59022	Inverness	59530	Pryor	59066		
Custer	59024	Jackson	59736	Ravalli	59863		
Cut Bank	59427	Jefferson City	59638	Raynesford	59469		
Darby	59829	Joliet	59041	Red Lodge	59068		
Dayton	59914	Joplin	59531	Rexford	59930		
De Borgia	59830	Judith Gap	59453	Ringling	59642		
Deer Lodge	59722	Kalispell	59901	Roberts	59070		
Dell	59724		59903-59904	Rollins	59931		
Dillon	59725	Kevin	59454	Ronan	59864		
Divide	59727						

NEW WEST MANAGED CARE AREAS

City	Zip Code	City	Zip Code	City	Zip Code	City	Zip Code
Absarokee	59001	Coram	59913	Helena	59601-59602	Noxon	59853
Acton	59002	Corvallis	59828		59604	Oilmont	59466
Alberton	59820	Crane	59217		59620	Opportunity	59711
Alder	59710	Creston	59901		59623-59626	Outlook	59252
Amsterdam	59741	Crow Agency	59022	Heron	59844	Pablo	59855
Anaconda	59711	Custer	59024	Highwood	59450	Paradise	59856
Angela	59312	Cut Bank	59427	Hilger	59451	Park City	59063
Antelope	59211	Dagmar	59219	Hingham	59528	Peerless	59253
Apgar	59936	Darby	59829	Hobson	59452	Pendroy	59467
Arlee	59821	Dayton	59914	Hot Springs	59845	Philipsburg	59858
Armington	59412	Deer Lodge	59722	Hungry Horse	59919	Pinesdale	59841
Augusta	59410	Denton	59430	Huntley	59037	Plains	59859
Avon	59713	Dillon	59725	Huson	59846	Plentywood	59254
Bainville	59212	Divide	59727	Hysham	59038	Polaris	59746
Ballantine	59006	Dixon	59831	Inverness	59530	Polebridge	59928
Basin	59631	Dodson	59524	Jefferson City	59638	Polson	59860
Bearcreek	59007	Drummond	59832	Joliet	59041	Pompeys Pillar	59064
Belfry	59008	Dupuyer	59432	Joplin	59531	Pony	59747
Belgrade	59714	Dutton	59433	Jordan	59337	Potomac	59823
Belt	59412	East Helena	59635	Judith Gap	59453	Power	59468
Big Arm	59910	Edgar	59026	Kalispell	59901-59904	Pray	59065
Big Sandy	59520	Elliston	59728	Kevin	59454	Proctor	59929
Big Sky	59716	Elmo	59915	Kila	59920	Pryor	59066
Big Timber	59011	Emigrant	59027	Kinsey	59338	Radersburg	59641
Bigfork	59911	Ennis	59729	Kremlin	59532	Ramsay	59748
Billings	59101-59108	Ethridge	59435	Lake McDonald	59921	Rapelje	59067
	59111-59112	Fairfield	59436	Lakeside	59922	Ravalli	59863
	59114-59117	Fairview	59221	Lambert	59243	Raymond	59256
Black Eagle	59414	Fallon	59326	Laurel	59044	Raynesford	59469
Bonner	59823	Fishtail	59028	Lavina	59046	Red Lodge	59068
Boulder	59632	Flaxville	59222	Ledger	59456	Red Stone	59257
Box Elder	59521	Florence	59833	Lewistown	59457	Reed Point	59069
Boyd	59013	Flowerree	59440	Libby	59923	Richland	59260
Bozeman	59715	Forest Grove	59441	Livingston	59047	Ringling	59642
	59717-59719	Forsyth	59327	Lloyd	59535	Roberts	59070
	59771-59773	Fort Benton	59442	Lodge Grass	59050	Rocker	59701
Brady	59416	Fort Harrison	59636	Lolo	59847	Rollins	59931
Bridger	59014	Fort Shaw	59443	Loma	59460	Ronan	59864
Broadview	59015	Frenchtown	59834	Lonepine	59848	Roscoe	59071
Brusett	59318	Fromberg	59029	Loring	59537	Rosebud	59347
Buffalo	59418	Galata	59444	Malta	59538	Roundup	59072-59073
Butte	59701-59703	Gallatin Gateway	59730	Malmstrom AFB	59402	Roy	59471
	59707	Galen	59722	Manhattan	59741	Rudyard	59540
	59750	Garneill	59445	Marion	59925	Ryegate	59074
Bynum	59419	Garrison	59731	Martin City	59926	Saco	59261
Cameron	59720	Garryowen	59031	Martinsdale	59053	Saint Ignatius	59865
Canyon Creek	59633	Georgetown	59711	Marysville	59640	Saint Regis	59866
Cardwell	59721	Geraldine	59446	McLeod	59052	Saint Xavier	59075
Carter	59420	Gildford	59525	Melville	59055	Sand Coulee	59472
Cascade	59421	Glen	59732	Mildred	59341	Sanders	59076
Charlo	59824	Gold Creek	59733	Miles City	59301	Santa Rita	59473
Chester	59522	Grantsdale	59835	Milltown	59851	Scobey	59263
Chinook	59523	Grass Range	59032	Missoula	59801-59804	Shawmut	59078
Choteau	59422	Great Falls	59401		59806-59808	Shelby	59474
Clancy	59634		59403-59406		59812	Shepherd	59079
Clinton	59825	Greenough	59836	Moccasin	59462	Sheridan	59749
Clyde Park	59018	Grey cliff	59033	Moiese	59824	Sidney	59270
Cohagen	59322	Hall	59837	Molt	59057	Silver Star	59751
Colstrip	59323	Hamilton	59840	Montana City	59634	Simms	59477
Columbia Falls	59912	Hardin	59034	Moore	59464	Snider	59873
Columbus	59019	Harlowton	59036	Musselshell	59059	Somers	59932
Condon	59826	Harrison	59735	Neihart	59465	Springdale	59082
Connor	59827	Hathaway	59333	Niarada	59845	Stevensville	59870
Conrad	59425	Havre	59501	Norris	59745	Stockett	59480

MANAGED CARE AREAS

NEW WEST CONTINUED

City	Zip Code
Stryker	59933
Sula	59871
Sun River	59483
Sunburst	59482
Superior	59872
Swan Lake	59911
Terry	59349
Thompson Falls	59873
Three Forks	59752
Toston	59643
Townsend	59644
Tracy	59472
Troy	59935
Turah	59825
Twin Bridges	59754
Two Dot	59085
Ulm	59485
Valier	59486
Vaughn	59487
Victor	59875
Virginia City	59755
Walkerville	59701
Warm Springs	59756
Westby	59275
West Glacier	59936
Whitefish	59937
White Sulphur Springs	59645
Whitehall	59759
Whitetail	59276
Whitewater	59544
Wilsall	59086
Winston	59647
Wolf Creek	59648
Worden	59088
Zurich	59547

PARTICIPATING FACILITIES - TRADITIONAL PLAN

Preferred 20% Coinsurance

Anaconda	Community Hospital of Anaconda
Baker	Fallon Medical Complex
Big Sandy	Big Sandy Medical Center
Big Timber	Pioneer Medical Center
Billings	Advanced Care Hospital Billings Cataract and Laser Surgicenter Billings Clinic Hospital Health South Surgery Center LaGreca Eye Clinic/Surgicenter St. Vincent Healthcare Yellowstone Surgery Center
Bozeman	Bozeman Deaconess Hospital Rocky Mountain Surgical Center Same Day Surgery Center
Butte	St. James Healthcare Summit Surgery Center
Chester	Liberty County Hospital
Choteau	Teton Medical Center
Circle	McCone County Health Center
Columbus	Stillwater Community Hospital
Conrad	Pondera Medical Center
Culbertson	Roosevelt Memorial Medical Center
Cut Bank	Northern Rockies Medical Center
Deer Lodge	Powell County Memorial Hospital
Dillon	Barrett Hospital and Health Care
Ekalaka	Dahl Memorial Healthcare
Ennis	Madison Valley Hospital
Forsyth	Rosebud Health Care Center
Fort Benton	Missouri River Medical Center
Glasgow	Frances Mahon Deaconess Hospital
Glendive	Glendive Medical Center
Great Falls	Benefis Healthcare Central Montana Surgical Hospital Great Falls Clinic Surgery Center Pacific Cataract and Laser Institute
Hamilton	Marcus Daly Memorial Hospital
Hardin	Big Horn County Memorial Hospital
Harlowton	Wheatland Memorial Hospital
Havre	Northern Montana Hospital

Helena	Helena Surgicenter Shodair Hospital St. Peter's Hospital
Jordan	Garfield County Health Center
Kalispell	Healthcenter Northwest Kalispell Regional Medical Center Orthopedic Surgery Center
Lewistown	Central Montana Medical Center
Libby	St. John's Lutheran Hospital
Livingston	Livingston Healthcare
Malta	Phillips County Medical Center
Miles City	Holy Rosary Healthcare
Missoula	Big Sky Surgery Center Community Medical Center Missoula Bone & Joint Surgery Center Providence Surgery Center St. Patrick Hospital and Health Sci-
ences	
Philipsburg	Granite County Medical Center
Plains	Clark Fork Valley Hospital
Plentywood	Sheridan Memorial Hospital
Polson	St. Joseph Hospital
Poplar	Poplar Community Hospital
Red Lodge	Beartooth Hospital and Health Center
Ronan	St. Luke Community Hospital
Roundup	Roundup Memorial Hospital
Scobey	Daniels Memorial Hospital
Shelby	Marias Medical Center
Sheridan	Ruby Valley Hospital
Sidney	Sidney Health Center
Superior	Mineral Community Hospital
Terry	Prairie Community CAH
Townsend	Broadwater Health Center
Whitefish	North Valley Hospital
White Sulphur Springs	Mountainview Medical Center
Wolf Point	Northeast Montana Health Services

Non-preferred 35% Coinsurance

All other 25% Coinsurance

PARTICIPATING HOSPITALS - MANAGED CARE PLANS

BLUE CHOICE

City	Hospital
Anaconda	Community Hospital of Anaconda
Billings	Advanced Care Hospital Billings Clinic Hospital St. Vincent Healthcare
Bozeman	Bozeman Deaconess Hospital
Butte	St. James Healthcare
Chester	Liberty County Hospital
Choteau	Teton Medical Center
Conrad	Pondera Medical Center
Dillon	Barrett Memorial Hospital
Ennis	Madison Valley Hospital
Fort Benton	Missouri River Medical Center
Great Falls	Benefis Healthcare Central Montana Surgical Hospital
Hamilton	Marcus Daly Memorial Hospital
Hardin	Big Horn County Memorial Hospital
Harlowton	Wheatland Memorial Hospital
Havre	Northern Montana Hospital
Helena	Helena Surgi Center Shodair Hospital St. Peter's Hospital
Kalispell	Healthcenter Northwest Kalispell Regional Medical Center
Livingston	Livingston Memorial Hospital
Miles City	Holy Rosary Healthcare
Missoula	Community Medical Center St. Patrick Hospital
Phillipsburg	Granite Co Medical Center Hospital
Plains	Clark Fork Valley Hospital
Polson	St. Joseph Hospital
Red Lodge	Beartooth Hospital and Health Center
Ronan	St. Luke Community Hospital
Roundup	Roundup Memorial Hospital
Shelby	Marias Medical Center
Sheridan	Ruby Valley Hospital
Superior	Mineral Community Hospital
Townsend	Broadwater Health Center
White Sulphur Springs	Mountainview Medical Center
Whitefish	North Valley Hospital

NEW WEST HEALTH PLAN

City	Hospital
Anaconda	Community Hospital of Anaconda
Big Sandy	Big Sandy Medical Center
Big Timber	Pioneer Medical Center
Billings	Billings Clinic Hospital
Bozeman	Bozeman Deaconess Hospital
Butte	St. James Healthcare
Chester	Liberty County Medical Center
Chinook	Sweet Medical Center
Choteau	Teton Medical Center
Columbus	Stillwater Community Hospital
Conrad	Pondera Medical Center
Deer Lodge	Powell County Memorial Hospital
Dillon	Barrett Hospital & Healthcare
Forsyth	Rosebud Health Care Center
Fort Benton	Missouri River Medical Center
Great Falls	Benefis Healthcare
Hamilton	Marcus Daly Memorial Hospital
Hardin	Big Horn County Hospital
Harlowton	Wheatland Memorial Hospital
Havre	Northern Montana Hospital
Helena	St. Peter's Hospital
Jordan	Garfield County Health Center
Kalispell	Kalispell Regional Medical Center
Lewistown	Central Montana Medical Center
Libby	St. John's Lutheran Hospital
Livingston	Livingston Memorial Hospital
Malta	Phillips County Hospital
Miles City	Holy Rosary Healthcare
Missoula	Community Medical Center
Phillipsburg	Granite County Medical Center Hospital
Plains	Clark Fork Valley Hospital
Plentywood	Sheridan Memorial Hospital
Red Lodge	Beartooth Hospital
Ronan	St. Luke Community Hospital
Roundup	Roundup Memorial Healthcare
Scobey	Daniels Memorial Healthcare Center
Shelby	Marias Medical Center
Sidney	Sidney Health Center
Superior	Mineral Community Hospital
Terry	Prairie Community Health Center
Townsend	Broadwater Health Center
White Sulphur Springs	Mountainview Medical Center
Whitefish	North Valley Hospital

WORKERS' COMPENSATION MANAGEMENT PROGRAM



Sponsored by the Health Care and Benefits Division - Department of Administration
Workers' Compensation Management Bureau
1-800-287-8266 or 444-7462 • www.benefits.mt.gov

GENERAL INFORMATION

PROGRAM DESCRIPTION

The Workers' Compensation Management Bureau has been charged with developing programs designed to enhance the safety of all work environments, assist our injured workers in their healing process, and ensure that all injured State of Montana employees receive the best care possible and are returned to work as soon as possible following work-related injuries or occupational diseases.

This will improve the well-being of all employees and provide for an efficient workers' compensation program. This program, sponsored by the Department of Administration, assists employees and agencies in ensuring a safe working environment, reduces the incidents of injuries and accidents in the workplace, and helps employees who are injured to be able to return to meaningful and productive work as soon as possible.

WHO IS ELIGIBLE

All State employees are eligible for these programs.

WORKING SAFELY - GETTING STARTED

The first step toward keeping yourself and your workplace injury-free is awareness of the safety and loss-prevention tools available to you.

1. Be aware of your environment and head off problems. Participate in safety seminars and programs if available and learn about keeping yourself, your work environment, and your coworkers free from injury.

2. Use proper safety equipment and follow recommended safety standards and protocols. Get the right equipment for the job and avoid injury (that includes office work – repetitive motion injuries are a significant portion of our experience within the State).

3. Take safety seriously. A moment of distraction or carelessness is all it takes to cause a lifetime of disability.

4. Take responsibility individually for keeping yourself safe and observing the safety of others.

Employees who are eligible for health insurance benefits can also take advantage of the various programs available through their benefits package. The Health Care and Benefits Division offers several programs to enhance and protect the health of State of Montana employees. Please refer to pages 23 & 24 for more information on these programs aimed at enhancing overall health and reducing the potential for injury.

SAFETY RESOURCES

Safety is an integral part of the Workers' Compensation Management programs for State employees. Safety newsletters, workshops, posters, incentive programs, and articles are key components in communicating effectively. Department of Administration, Department of Labor, and Montana State Fund are cooperating to make sure workers have access to safety management services to reduce the overall number of work related injuries and occupational diseases.

Please check within your agency to determine what resources exist as well. Agencies have safety personnel or someone tasked with safety responsibilities who can assist in making sure you have the resources and information you need.

FRAUD FINDERS

What is fraud? It is more than an employee faking an injury. It encompasses medical providers authorizing and billing excessive or uncompleted medical services or employers falsifying payroll records to lower premiums. When fraud occurs, it costs all of us, and it is **AGAINST THE LAW!** To report suspicious activity, you can either fill out State Fund's Internet Reporting Form (accessible from the *On-line Tools/Report Fraud* section of their website), or call their Fraud Hotline: 888-MTCRIME (888-682-7463). All contacts will remain strictly confidential.

REPORTING AN INJURY

Work related injuries and occupational diseases must be reported to our Workers' Compensation insurance carrier, the Montana State Fund. The employee and manager are required to fill out and submit an employer's "First Report of Injury" within 24 hours of the accident. Reporting for occupational diseases should be done as quickly as possible.

Notice to Enrollees in a Self-Funded Nonfederal Governmental Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local government employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is “self-funded” by the employer, rather than provided through a health insurance policy. The State of Montana has elected to exempt the State of Montana (SOM) Employee Group Benefit Plan from the following requirement:

Parity in the application of certain limits to mental health benefits

The exemption from this Federal requirement will be in effect for the plan year beginning January 1, 2011 and ending December 31, 2011. The election may be renewed for subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a “certificate of creditable coverage” when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer’s health plan, or if you wish to purchase an individual health insurance policy. Please contact the State of Montana, Health Care and Benefits Division, at (406) 444-7462 or 1-800-287-8266 for more information regarding a certification of creditable coverage or with any questions.

STATE OF MONTANA

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Health Information Privacy

This Notice is required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and is intended to describe how the State of Montana health plan, State of Montana Employee Benefit Plan (“Health Plan”), will protect your health information with respect to its self-insured health benefits. References below to Health Plan shall mean the medical, prescription drug, dental, vision, employee assistance and healthcare flexible spending account benefits provided by the Health Plan.

“Health information” for this purpose means information that identifies you and either relates to your physical or mental health condition, or relates to the payment of your health care expenses. This individually identifiable health information is known as “protected health information” (“PHI”). Your PHI will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by federal or state health information privacy laws.

Health Plan Privacy Obligations

The Health Plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this Notice of its legal duties and privacy practices with respect to health information about you; and

- Follow the terms of the Notice that are in effect.

How the Health Plan May Use and Disclose Health Information About You

The Health Plan may use health information or disclose it to others for a number of different reasons. The following are the different ways that the Health Plan may use and disclose your PHI without your authorization:

- **For Treatment.** The Health Plan may disclose your PHI to a health care provider who provides, coordinates or manages health care treatment on your behalf. For example, if you are unable to provide your medical history as a result of an accident, the Health Plan may advise an emergency room physician about the different medications that you may have been prescribed.
- **For Payment.** The Health Plan may use and disclose your PHI so claims for health care treatment, services, and supplies that you receive from health care providers may be paid according to the Health Plan's terms. The Health Plan may also use your PHI for billing, reviews of health care services received, and subrogation. For example, the Health Plan may tell a doctor or hospital whether you are eligible for coverage or what percentage of the bill will be paid by the Health Plan.
- **For Health Care Operations.** The Health Plan may use and disclose your PHI to enable it to operate more efficiently or to make certain that all of its participants receive the appropriate health benefits. For example, the Health Plan may use your PHI for case management, to refer individuals to disease management programs, for underwriting, premium rating, activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, to arrange for medical reviews, or to perform population-based studies designed to reduce health care costs. In addition, the Health Plan may use or disclose your PHI to conduct compliance reviews, audits, legal reviews, actuarial studies, and/or for fraud and abuse detection. The Health Plan may also combine health information about participants and disclose it to the State of Montana in a non-identifiable, summary fashion so that the State of Montana can decide, for example, what types of coverage the Health Plan should provide. The Health Plan may also remove information that identifies you from health information that is disclosed to the State of Montana so that the health information that is used by the State of Montana does not identify the specific Health Plan participants.
- **To The Plan Sponsor.** The Health Plan is sponsored by the State of Montana. The Health Plan may disclose your PHI to designated personnel at the State of Montana so that they can carry out related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the individuals authorized to receive such information under the Health Plan. These individuals will protect the privacy of your health information and ensure that it is used only as described in this Notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Health Plan to any other employee or department of the State of Montana and (2) will not be used by the State of Montana for any employment-related actions or decisions, or in connection with any other employee benefit plans sponsored by the State of Montana.
- **To a Business Associate.** Certain services are provided to the Health Plan by third-party administrators known as "business associates." For example, the Health Plan may place information about your health care treatment into an electronic claims processing system maintained by a business associate so that your claim may be paid. In so doing, the Health Plan will disclose your PHI to its business associates so that the business associates can perform their claims payment functions. However, the Health Plan will require its business associates, through written agreements, to appropriately safeguard your health information.
- **For Treatment Alternatives.** The Health Plan may use and disclose your PHI to tell you about possible treatment options or health care alternatives that may be of interest to you.
- **For Health-Related Benefits and Services.** The Health Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

- **To Individuals Involved in Your Care or Payment of Your Care.** The Health Plan may disclose PHI to a close

friend or family member involved in or who helps pay for your health care. The Health Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death, unless other laws would prohibit such disclosures.

- **As Required by Law.** The Health Plan will disclose your PHI when required to do so by federal, state, or local law, including those laws that require the reporting of certain types of wounds, illnesses or physical injuries.

Special Use and Disclosure Situations

The Health Plan may also use or disclose your PHI without your authorization under the following circumstances:

- **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the Health Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other forms of lawful due process.
- **Law Enforcement.** The Health Plan may release your PHI if asked to do so by a law enforcement official, for example, to report child abuse, to identify or locate a suspect, material witness, missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.
- **Workers' Compensation.** The Health Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs.
- **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Health Plan may release medical information about you as deemed necessary by military command authorities.
- **To Avert Serious Threat to Health or Safety.** The Health Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
- **Public Health Risks.** The Health Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medications or problems with medical products, or to notify people of recalls of products they have been using.
- **Health Oversight Activities.** The Health Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- **Research.** Under certain limited circumstances, the Health Plan may use and disclose your PHI for medical research purposes.
- **National Security, Intelligence Activities, and Protective Services.** The Health Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law, and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- **Organ and Tissue Donation.** If you are an organ donor, the Health Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- **Coroners, Medical Examiners, and Funeral Directors.** The Health Plan may release your PHI to a coroner or medical

examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Health Plan may also release your PHI to a funeral director, as necessary, to carry out his/her responsibilities.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information that the Health Plan maintains about you:

- **Right to Inspect and Copy Your Personal Health Information.** You have the right to inspect and copy your PHI that is maintained in a “designated record set” for so long as the Health Plan maintains your PHI. A “designated record set” includes medical information about eligibility, enrollment, claim and appeal records, and medical and billing records maintained by the Health Plan, but does not include psychotherapy notes, information intended for use in a civil, criminal or administrative proceeding, or information that is otherwise prohibited by law.

To inspect and copy health information maintained by the Health Plan, submit your request in writing to the Privacy Official. The Health Plan may charge a fee for the cost of copying and/or mailing your request. The Health Plan must act upon your request for access no later than 30 days after receipt (60 days if the information is maintained off-site). A single, 30-day extension is allowed if the Health Plan is unable to comply by the initial deadline. In limited circumstances, the Health Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to your health information, you will be informed as to the reasons for the denial, and of your right to request a review of the denial.

You may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any must be reasonable and based on the Health Plan’s cost.

- **Right to Amend Your Personal Health Information.** If you feel that the health information that the Health Plan has about you is incorrect or incomplete, you may ask the Health Plan to amend it. You have the right to request an amendment for so long as the Health Plan maintains your PHI in a designated record set.

To request an amendment, send a detailed request in writing to the Privacy Official. You must provide the reason(s) to support your request. The Health Plan may deny your request if you ask the Health Plan to amend health information that was: (1) accurate and complete; (2) not created by the Health Plan; (3) not part of the health information kept by or for the Health Plan; or (4) not information that you would be permitted to inspect and copy. The Health Plan has 60 days after the request is received to act on the request. A single, 30-day extension is allowed if the Health Plan cannot comply by the initial deadline. If the request is denied, in whole or in part, the Health Plan will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and, if permitted under HIPAA, have that statement included with any future disclosures of your PHI.

- **Right to An Accounting of Disclosures.** You have the right to request an “accounting of disclosures” of your PHI. This is a list of disclosures of your PHI that the Health Plan has made to others for the six (6) year period prior to the request, except for those disclosures necessary to carry out treatment, payment, or health care operations, disclosures previously made to you, disclosures that occurred prior to the date on which the accounting is requested, or in certain other situations described under HIPAA.

To request an accounting of disclosures, submit your request in writing to the Privacy Official. Your request must state a time period, which may not be longer than six (6) years prior to the date the accounting was requested. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the Health Plan provides you with a written statement of the reasons for the delay and the date by when the accounting will be provided. If you request more than one accounting within a 12-month period, the Health Plan will charge a reasonable, cost-based fee for each subsequent accounting.

- **Right to Request Restrictions.** You have the right to request a restriction on the health information that the Health Plan uses or discloses about you for treatment, payment, or health care operations. You also have the right to request

that the Health Plan limits the individuals (for example, family members) to whom the Health Plan discloses health information about you. For example, you could ask that the Health Plan not use or disclose information about a surgical procedure that you had. While the Health Plan will consider your request, it is not required to agree to it except in those situations where the requested restriction relates to the disclosure to the Plan for purposes of carrying out payment or health care operations (and not for treatment, and the Protected Health Information pertains solely to a health care item or service that was paid for out of pocket in full. If the Health Plan agrees to the restriction, it will comply with your request until such time as the Health Plan provides written notice to you of its intent to no longer agree to such restriction, or unless such disclosure is required by law.

To request a restriction or limitation, make your request in writing to the Privacy Official. In your request, you must state: (1) what information you want to limit; (2) whether you want to limit the Health Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. Note: the Health Plan is not required to agree to your request.

- **Right to Request Confidential Communications.** You have the right to request that the Health Plan communicates with you about health matters using alternative means or at alternative locations. For example, you can ask that the Health Plan send your explanation of benefits ("EOB") forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Official. The Health Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you want to be contacted.
- **State Privacy Rights.** You may have additional privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.
- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. You may write to the Privacy Official to request a written copy of this Notice at any time.

Changes to this Privacy Notice

The Health Plan reserves the right to change this Notice at any time and from time to time, and to make the revised or changed Notice effective for health information that the Health Plan already has about you, as well as any information that the Health Plan may receive in the future. The revised Notice will be provided to you in the same manner as this Notice, or electronically if you have consented to receive the Notice electronically.

Complaints

If you believe that your health information privacy rights as described under this Notice have been violated, you may file a written complaint with the Health Plan by contacting the person listed at the address under "Contact Information". You may also file a written complaint directly with the regional office of the U.S. Department of Health and Human Services, Office for Civil Rights. The complaint should generally be filed within 180 days of when the act or omission complained of occurred. Note: You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this Notice or by the laws that apply to the Health Plan will be made only with your written authorization. If you authorize the Health Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Health Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Health Plan will not reverse any uses or disclosures already made in reliance on your prior authorization. The Plan will notify you in the event that there is a breach involving unsecured Protected Health Information.

Contact Information

To receive more information about the Health Plan's privacy practices or your rights, or if you have any questions about this Notice, please contact the Health Plan at the following address:

Contact Office or Person: Amber Godbout, Privacy Official

Health Plan Name: State of Montana Employee Benefit Plan

Telephone: (406) 444-7462 (in Helena) or

(800) 287-8266

Address: Health Care and Benefits Division

PO Box 200130

Helena, MT 59620-0130

Email: agodbout@mt.gov

Copies of this Notice are also available at 100 North Park Avenue, Suite 320, Helena, MT 59601 and on our web site <http://www.benefits.mt.gov>. This Notice is also available by sending an e-mail to the above address.

Effective and Last Updated: February 17, 2010

Notice of Grandfathered Status

This group health plan meets the criteria for a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to non-grandfathered plans; for example, the requirements for providing preventative health services without any cost sharing. However, in order to maintain grandfathered status the plan must meet stringent requirements of the Affordable Care Act; for example, minimum premium, copayment and coinsurance increases. In addition, maintaining the grandfather status will allow the plan more time to develop a comprehensive wellness and preventive services benefit package. Grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of some annual and lifetime limits on benefits and the coverage of dependent children up to the age of 26.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan at 1-800-287-8266. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

DISCLAIMER: The Patient Protection and Affordable Care Act (PPACA) was enacted on March 23, 2010. The United States Departments of Health and Human Services, Labor and Treasury have issued regulations to help entities comply with PPACA. However, additional clarifications to address issues that may arise under these regulations could also be published by the Departments on an on-going manner through administrative guidance possibly in another form than a regulation. Where the statutes or regulations were not clear regarding benefits, the State of Montana made a reasonable interpretation of the Act and made a good faith effort to comply with the statutes and regulations. The State of Montana reserves the right to alter provisions of this document and its plan in order to comply with applicable law.